AMENDED IN SENATE JUNE 9, 2011

AMENDED IN SENATE MARCH 14, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 106

Introduced by Committee on Budget (Blumenfield (Chair), Alejo, Allen, Brownley, Buchanan, Butler, Cedillo, Chesbro, Dickinson, Feuer, Gordon, Huffman, Mitchell, Monning, and Swanson)

January 10, 2011

~~An act to amend Sections 16325, 16325.5, 16326, and 70371.5 of, and to add Sections 16328 and 16329 to, the Government Code, to repeal Section 2103.1 of the Streets and Highways Code, and to amend Section 14167.35 of the Welfare and Institutions Code, relating to state cash resources, and making an appropriation therefor, and declaring the urgency thereof, to take effect immediately, bill related to the budget.~~*An act to amend Sections 1179.3, 1771, 1771.7, 1771.8, 1776.3, 1783.3, 1785, 1793.13, 1793.23, 1793.50, 1793.60, 127280, 128680, 128700, 128705, 128738, 128740, 128745, 128750, 128760, 128765, 128770, 128775, 128785, 128810, 129010, 129015, and 129100 of, and to repeal Sections 1179.2, 1179.5, 1777, 1777.2, 1777.4, 127670, 127671, 128695, 128710, 128715, 128720, and 128725 of, the Health and Safety Code, and to amend Sections 10618.6, 11265.2, 11320.15, 11320.3, 11322.63, 11329.5, 11334.8, 11364, 11387, 11405, 11454, 11454.2, 11461, 11462.04, 11465, 11466.23, 11487, 12200.03, 12301.03, 12301.05, 12309.1, 14132.97, 16120.05, 16121, 16519.5, and 17021 of, to add Sections 11487.1, 14021.30, and 14021.31 to, and to repeal Sections 11450.025 and 16121.01 of, the Welfare and Institutions Code, relating to human services, making an appropriation therefor, to take effect immediately, bill related to the budget.*

LEGISLATIVE COUNSEL'S DIGEST

AB 106, as amended, Committee on Budget. ~~State cash resources.~~ *Human services.*

Existing law requires the establishment of the Office of Rural Health, or an alternative organizational structure, in one of the departments of the California Health and Human Services Agency, and requires the office or alternative organizational structure to serve as a key information and referral source to promote coordinated planning for the delivery of health services in rural California. Under existing law, various functions relating to rural health activities are performed by the Rural Health Policy Council. Existing law also requires the establishment of an interdepartmental Task Force on Rural Health, to coordinate rural health policy development and program operations and develop a strategic plan for rural health, as specified.

This bill, operative January 1, 2012, would eliminate the Rural Health Policy Council and the interdepartmental task force, and would transfer designated duties of these entities to the Office of Statewide Health Planning and Development.

Existing law establishes, until January 1, 2013, the Continuing Care Advisory Committee within the State Department of Social Services and requires the committee to act in an advisory capacity to the department on matters relating to continuing care contracts.

This bill, operative January 1, 2012, would delete the committee and make conforming changes.

Existing law creates the Health Care Quality Improvement and Cost Containment Commission, as specified, to research and recommend appropriate and timely strategies for promoting high quality care and containing health care costs.

Existing law creates the California Health Policy and Data Advisory Commission, as specified. Under existing law, the commission has prescribed functions and duties, including advising the Office of Statewide Health Planning and Development, on issues relating to health facility and other provider data.

This bill, operative January 1, 2012, would eliminate the Health Care Quality Improvement and Cost Containment Commission. The bill also would eliminate California Health Policy and Data Advisory Commission and would transfer its duties to the office, or to an entity designated by the office, as prescribed. The bill would make various related technical and conforming changes.

Existing law requires a county welfare department to request a consumer disclosure, pursuant to federal law, on behalf of a youth in a foster care placement in the county, when the youth reaches his or her 16th birthday, in order to ascertain whether the youth has been the victim of identity theft, as specified.

This bill would suspend implementation of the above provisions until July 1, 2013.

Existing federal law provides for allocation of federal funds through the federal Temporary Assistance for Needy Families (TANF) block grant program to eligible states. Existing law provides for the California Work Opportunity and Responsibility to Kids (CalWORKs) program under which, through a combination of state and county funds and federal funds received through the TANF program, each county provides cash assistance and other benefits to qualified low-income families. Under existing law, operative as specified, a parent or caretaker relative is not eligible for CalWORKs aid after he or she has received CalWORKs aid for a cumulative total of 48 months, or TANF aid from any state for a cumulative total of 60 months.

This bill would impose a 48-month limit on the receipt of aid, regardless of whether received under the CalWORKs program or another state's TANF program, and would make various conforming changes.

Existing law requires recipients of aid under the CalWORKs program who are under 19 years of age who are pregnant or custodial parents to participate in certain educational programs, which are referred to as the Cal-Learn Program. Under existing law, a Cal-Learn Program participant is entitled to monetary supplements or bonuses, as specified, for maintaining satisfactory educational progress, and successfully completing high school or a California high school equivalency examination. Existing law suspends operation of the Cal-Learn Program from July 1, 2011, to June 30, 2012, inclusive, except as specified. Under existing law, certain pregnant women with no other children, who are eligible for the Cal-Learn Program, are also eligible for CalWORKs aid, but only when the Cal-Learn Program is operative.

This bill, notwithstanding existing law, would authorize certain pregnant women, who are determined to be eligible for aid for purposes of participating in the Cal-Learn Program prior to July 1, 2011, to continue to receive aid during the suspension of the Cal-Learn Program, as specified. Because moneys are continuously appropriated from the General Fund to pay for the states share of CalWORKs program costs,

by expanding eligibility, this bill would make an appropriation. In addition, by increasing county duties, the bill would impose a state-mandated local program.

Existing law provides that when aid under the CalWORKs program is repaid to the state, the state is entitled to the entire amount of the aid repaid, except where federal and county funds were paid, in which case the federal government remains entitled to a proportionate share of the amount received or recovered and the county remains entitled to its proportionate share, except for county funds received or recovered during the 2011–12 fiscal year, which are retained by the state.

This bill would restrict the above repayment procedures to situations when the aid repaid to the state is by means of child support collections. The bill would require that when any other aid is repaid to, or recovered by, a county, the state and the federal government would be entitled to a share of the amount received or recovered, proportionate to the amount of state or federal funds paid.

Existing law, as of July 1, 2011, reduces the amount of the CalWORKs computed aid grant in a child-only assistance unit by 5% commencing with the 61st, 73rd, and 85th months on aid, respectively, for a total 15% reduction.

This bill would eliminate the above-described grant reduction, and make conforming changes. The bill would authorize the department to implement this change through all-county letters or similar instructions pending the adoption of regulations.

Existing law makes specified findings and declarations with respect to the effect of decreased funding for CalWORKS for the 2009–10 to 2011–12 fiscal years, inclusive. In connection with this decreased funding, existing law extends certain exemptions from months counted as a month of receipt of aid, and allows counties to redirect funding between specified employment assistance and substance abuse treatment programs during the specified fiscal years. Existing law authorizes a county to revise a specified welfare-to-work exemption in order to implement the county's portion of this funding reduction.

This bill would revise the amount of the funding reduction applicable to the 2011–12 fiscal year, as specified, and would delete the county authority to revise the above-referenced welfare-to-work exemption.

Existing law provides for the In-Home Supportive Services (IHSS) program, under which, either through employment by the recipient, or by or through contract by the county, qualified aged, blind, and disabled persons receive services enabling them to remain in their own homes.

Counties are responsible for the administration of the IHSS program. Under the Medi-Cal program, similar services are provided to eligible individuals, with these services known as personal care option services. Under existing law, operative as specified, if the Department of Finance makes a specified determination, the State Department of Social Services is required to implement a reduction in authorized IHSS program service hours, in accordance with prescribed procedures. Existing law authorizes an individual who believes that he or she is at serious risk of out-of-home placement, unless all or part of the reduction is restored, to apply for an IHSS Care Supplement to restore the reduced hours.

This bill would recast and revise the provisions relating to the IHSS service hours reduction and IHSS Care Supplement, including exempting certain IHSS recipients, who also receive other designated public health and social services, from the service hour reduction, and making other technical and conforming changes to these provisions.

This bill would revise the definition of "waiver personal care services" received by certain recipients under the Medi-Cal program, to delete the requirement prohibiting waiver personal care services from replacing any hours of services authorized or reduced pursuant to other designated service categories.

Existing law requires an IHSS applicant or recipient to obtain a certification from a licensed health care professional, as specified, as a condition of receiving those services. Existing law authorizes the receipt of services prior to certification under certain circumstances, including when deterioration of the recipient's health or mental health is likely to result in eviction, homelessness, or a hazardous living environment.

This bill would revise the circumstances under which services may be authorized prior to receipt of certification, to delete the authority described above, and to authorize, instead, provision of services based upon a county determination that there is a risk of out-of-home placement.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

Existing law provides for the Medi-Cal Drug Treatment Program (Drug Medi-Cal), under which each county enters into contracts with the State Department of Alcohol and Drug Programs for the provision

of various drug treatment services to Medi-Cal recipients, or the department directly arranges for the provision of these services if a county elects not to do so.

This bill would declare the intent of the Legislature to transfer Drug Medi-Cal functions from the State Department of Alcohol and Drug Programs to the State Department of Health Care Services, effective July 1, 2012, in accordance with an administrative and programmatic transition plan developed by the State Department of Health Care Services and the State Department of Alcohol and Drug Programs, as required in the bill.

Existing law requires the State Department of Social Services, in consultation with county welfare agencies, to implement a pilot program to establish a unified resource family approval process to replace the existing multiple processes for licensing foster family homes, approving relatives and nonrelative extended family members as foster care providers, and approving adoptive families, as specified. Existing law authorizes the pilot program to continue through the end of the 2010–11 fiscal year, or the end of the 3rd fiscal year following the date that funds are made available for its implementation, whichever is later.

This bill would extend authority for implementation of the resource family approval pilot program through the end of the 5th fiscal year following the date that funds are made available for that purpose. The bill also would suspend implementation of the pilot program until January 1, 2013.

Existing law provides for the out-of-home placement of children who are unable to remain in the custody and care of their parent or parents, and provides for a range of child welfare, foster care, and adoption assistance services for which these children may be eligible.

Existing law, through the Kinship Guardianship Assistance Payment Program (Kin-GAP), which is a part of the CalWORKs program, provides aid on behalf of eligible children who are placed in the home of a relative caretaker. The program is funded by state and county funding and available federal funds. Existing law, effective on the date that the Director of Social Services executes a prescribed declaration, revises the Kin-GAP Program by repealing the existing program and enacting similar provisions. Existing law requires as a condition of receiving payments under the revised Kin-GAP Program provisions, that a county welfare agency, probation department, or Indian tribe, as applicable, negotiate and enter into a written, binding kinship

guardianship assistance agreement with the relative guardian of an eligible child, as prescribed.

Existing law, the Aid to Families with Dependent Children-Foster Care (AFDC-FC) program, provides for payments to group home providers at a per child per month rate, and in accordance with prescribed rate classification levels, for the care and supervision of the AFDC-FC child placed with the provider. Existing law requires a county to annually redetermine AFDC-FC eligibility, as specified.

Existing law provides for the Adoption Assistance Program (AAP), to be established and administered by the State Department of Social Services or the county, for the purpose of benefiting children residing in foster homes by providing the stability and security of permanent homes. The AAP provides for the payment by the department and counties of cash assistance to eligible families that adopt eligible children, and bases the amount of the payment on the needs of the child and the resources of the family to meet those needs.

Existing law prohibits the establishment of a new group home rate or change to an existing rate under the AFDC-FC program for a prescribed period, and repeals this prohibition on January 1, 2012.

This bill would extend the prohibition on the establishment of a new or changed AFDC-FC group home rate until January 1, 2013.

Existing law declares the intent of the Legislature to comply with specified federal law relating to the overpayment of federal foster care and adoption assistance payments, under the AFDC-FC program, Kin-GAP program, and AAP. Existing law requires these funds to be repaid by the state and counties under designated circumstances. Existing law excludes certain amounts from this repayment requirement, and with respect to those amounts not excluded, requires repayment to be based on a 40% state, 60% county sharing ratio.

This bill would delete the existing sharing ratio, and instead would apply specified separate sharing ratios for repayment of federal AFDC-FC, Kin-GAP, and AAP funds, respectively.

This bill, with respect to agreements on or after July 1, 2011, would revise Kin-GAP, AFDC-FC, and AAP rates, as prescribed, and would annually adjust these rates by the percentage changes in the California Necessities Index, and make related changes. The bill would authorize implementation of these provisions through all-county letters or similar instructions from the department until regulations are adopted, as specified

Moneys from the General Fund are continuously appropriated for Kin-GAP, AFDC-FC, and AAP, as prescribed.

Because this bill, by increasing Kin-GAP, AFDC-FC, and AAP rates, and by revising existing sharing ratios for repayment of certain overpayments, would result in an increase in the state's level of participation in these programs in certain cases, this bill would make an appropriation.

Existing law requires the State Department of Social Services to implement a single statewide Child Welfare Services Case Management System (CWS/CMS) to administer and evaluate the state's child welfare services and foster care programs.

This bill would require the department, in partnership with the Office of Systems Integration and designated stakeholders, to perform various activities regarding the effectiveness and operation of the CWS/CMS, and to report on these activities to the Legislature, by January 10, 2012.

This bill would require the State Department of Social Services, in consultation with designated stakeholders, to develop a new rate-setting methodology for public authority administrative costs, effective for the 2012–13 fiscal year, and thereafter.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.

~~(1) Existing law, until September 1, 2011, provides for a cash management plan for the 2010–11 fiscal year to authorize the Controller, Treasurer, and Director of Finance to defer General Fund payments for up to 60 or 90 days, as specified, beginning July 2010, for specific entities, including county offices of education, public schools, and charter schools, subject to certain conditions.~~

~~This bill would modify these provisions and apply the cash management plan to the 2011–12 fiscal year. This bill would also establish specified procedures for deferrals, and repayment of those deferrals, from county offices of education, public schools, and charter~~

~~schools. The bill would make conforming changes and make these provisions inoperative on September 1, 2012.~~

~~(2) Existing law establishes the Immediate and Critical Needs Account of the State Court Facilities Construction Fund and the Hospital Quality Assurance Revenue Fund for the planning, financing, and construction of court facilities and the support and enhancement of hospital quality, respectively.~~

~~The bill would, notwithstanding existing law, authorize the Controller to use funds in the Immediate and Critical Needs Account and the Hospital Quality Assurance Revenue Fund for cashflow loans to the General Fund, as provided in specified provisions of law.~~

~~(3) Existing law provides for the deferral of specified apportionments on a pro rata basis from the Highway Users Tax Account in the Transportation Tax Fund to cities, counties, and cities and counties from July 2010 to March 2011, inclusive, and limits the amount of those deferrals. Existing law permits cities, counties, and cities and counties to borrow certain designated funds from their accounts and requires that any borrowing be repaid with interest that would be applied to a specified purpose.~~

~~The bill would repeal these provisions of law.~~

~~(4) The California Constitution authorizes the Governor to declare a fiscal emergency and to call the Legislature into special session for that purpose. Governor Schwarzenegger issued a proclamation declaring a fiscal emergency, and calling a special session for this purpose, on December 6, 2010. Governor Brown issued a proclamation on January 20, 2011, declaring and reaffirming that a fiscal emergency exists and stating that his proclamation supersedes the earlier proclamation for purposes of that constitutional provision.~~

~~This bill would state that it addresses the fiscal emergency declared and reaffirmed by the Governor by proclamation issued on January 20, 2011, pursuant to the California Constitution.~~

~~(5) This bill would appropriate the sum of $1,000 from the General Fund for administrative costs associated with this act.~~

~~(6) This bill would declare that it is to take effect immediately as a urgency statute and a bill providing for appropriations related to the Budget Bill.~~

Vote: ~~⅔~~ *majority*. Appropriation: yes. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. Section 1179.2 of the Health and Safety Code is repealed.

~~1179.2. (a) The Health and Welfare Agency shall establish an interdepartmental Task Force on Rural Health to coordinate rural health policy development and program operations and to develop a strategic plan for rural health.~~

~~(b) At a minimum, the following state departmental directors, or their representatives, shall participate on this task force:~~

~~(1) The Director of Health Services.~~

~~(2) The Director of Statewide Health Planning and Development.~~

~~(3) The Director of Alcohol and Drug Programs.~~

~~(4) The Director of the Emergency Medical Services Authority.~~

~~(5) The Director of Mental Health.~~

~~(6) The Executive Director of the Managed Risk Medical Insurance Board.~~

~~(c) The task force shall review and direct the activities of the Office of Rural Health or the alternative organizational structure, as determined by the Secretary of the Health and Welfare Agency.~~

~~(d) The task force shall establish appropriate mechanisms, such as ad hoc or standing advisory committees or the holding of public hearings in rural communities, for the purpose of soliciting and receiving input from these communities, including input from rural hospitals, rural clinics, health care service plans, local governments, academia, and consumers.~~

SEC. 2. Section 1179.3 of the Health and Safety Code is amended to read:

1179.3. (a) (1) The ~~Rural Health Policy Council~~ *Office of Statewide Health Planning and Development* shall develop and administer a competitive grants program for projects located in rural areas of California.

(2) The ~~Rural Health Policy Council~~ *office* shall define "rural area" for the purposes of this section after receiving public input and upon recommendation of the Interdepartmental Rural Health Coordinating Committee and the Rural Health Programs Liaison.

(3) The purpose of the grants program shall be to fund innovative, collaborative, cost-effective, and efficient projects that pertain to the delivery of health and medical services in rural areas of the state.

(4) The ~~Rural Health Policy Council~~ *office* shall develop and establish uses for the funds to fund special projects that alleviate problems of access to quality health care in rural areas and to compensate public and private health care providers associated with direct delivery of patient care. The funds shall be used for medical and hospital care and treatment of patients who cannot afford to pay for services and for whom payment will not be made through private or public programs.

(5) The ~~Office of Statewide Health Planning and Development~~ *office* shall administer the funds appropriated by the Legislature for purposes of this section. Entities eligible for these funds shall include rural health providers served by the programs operated by the ~~departments represented on the Rural Health Policy Council, which include the~~ *office, the* State Department of Alcohol and Drug Programs, the Emergency Medical Services Authority, the State Department of Health *Care* Services, *the State Department of Public Health,* the State Department of Mental Health, ~~the Office of Statewide Health Planning and Development,~~ and the Managed Risk Medical Insurance Board. The grant funds shall be used to expand existing services or establish new services and shall not be used to supplant existing levels of service. Funds appropriated by the Legislature for this purpose may be expended in the fiscal year of the appropriation or the subsequent fiscal year.

(b) The ~~Rural Health Policy Council~~ *Office of Statewide Health Planning and Development* shall establish the criteria and standards for eligibility to be used in requests for proposals or requests for application, the application review process, determining the maximum amount and number of grants to be awarded, preference and priority of projects, compliance monitoring, and the measurement of outcomes achieved after receiving comment from the public at a meeting held pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(c) The Office of Statewide Health Planning and Development shall ~~periodically report to the Rural Health Policy Council on~~ *make information regarding* the status of the funded projects. ~~This information shall also be~~ available at the public meetings *described in subdivision (b).*

SEC. 3. Section 1179.5 of the Health and Safety Code is repealed.

~~1179.5. (a) The Rural Health Policy Office within the Office of Statewide Health Planning and Development serving as staff to the Rural Health Policy Council shall develop an annual workplan which is adopted by the council. The workplan shall describe how the council shall meet specific, measurable performance objectives. The workplan shall be designed to further the goals of the Rural Health Policy Council to improve access to, and the quality of, health care in rural areas.~~

~~(b) The workplan required under subdivision (a) shall include information on how the council intends to address, at a minimum, all of the following topics:~~

~~(1) Increased standardization and consolidation of financial and statistical reporting, billing, audits, contracts, and budgets.~~

~~(2) Network delivery and integrated delivery systems.~~

~~(3) Streamlining the regulatory process.~~

~~(4) Assessing the impact of managed care in rural communities.~~

~~(5) Reviewing and proposing changes necessary to improve current funding issues.~~

~~(6) Increasing the use of technology.~~

~~(7) Supporting innovative efforts to improve patient transportation.~~

~~(8) Providing strategic planning for local communities.~~

~~(9) Improving communication between the state and rural providers.~~

~~(10) Increasing workforce availability in rural areas.~~

~~(c) The Rural Health Policy Council shall provide an annual report to the chairs of the fiscal and policy committees of the Legislature on the outcomes achieved by the office during the preceding 12 months and what changes it will incorporate into the workplan for the following year. The first report pursuant to this section shall be provided to the Legislature by February 1, 1999.~~

SEC. 4. Section 1771 of the Health and Safety Code is amended to read:

1771. Unless the context otherwise requires, the definitions in this section govern the interpretation of this chapter.

(a) (1) “Affiliate” means any person, corporation, limited liability company, business trust, trust, partnership, unincorporated association, or other legal entity that directly or indirectly controls,

is controlled by, or is under common control with, a provider or applicant.

(2) "Affinity group" means a grouping of entities sharing a common interest, philosophy, or connection (e.g., military officers, religion).

(3) "Annual report" means the report each provider is required to file annually with the department, as described in Section 1790.

(4) "Applicant" means any entity, or combination of entities, that submits and has pending an application to the department for a permit to accept deposits and a certificate of authority.

(5) "Assisted living services" includes, but is not limited to, assistance with personal activities of daily living, including dressing, feeding, toileting, bathing, grooming, mobility, and associated tasks, to help provide for and maintain physical and psychosocial comfort.

(6) "Assisted living unit" means the living area or unit within a continuing care retirement community that is specifically designed to provide ongoing assisted living services.

(7) "Audited financial statement" means financial statements prepared in accordance with generally accepted accounting principles including the opinion of an independent certified public accountant, and notes to the financial statements considered customary or necessary to provide full disclosure and complete information regarding the provider's financial statements, financial condition, and operation.

(b) (reserved)

(c) (1) "Cancel" means to destroy the force and effect of an agreement or continuing care contract.

(2) "Cancellation period" means the 90-day period, beginning when the resident physically moves into the continuing care retirement community, during which the resident may cancel the continuing care contract, as provided in Section 1788.2.

(3) "Care" means nursing, medical, or other health-related services, protection or supervision, assistance with the personal activities of daily living, or any combination of those services.

(4) "Cash equivalent" means certificates of deposit and United States treasury securities with a maturity of five years or less.

(5) "Certificate" or "certificate of authority" means the certificate issued by the department, properly executed and bearing the State Seal, authorizing a specified provider to enter into one

or more continuing care contracts at a single specified continuing care retirement community.

(6) "Condition" means a restriction, specific action, or other requirement imposed by the department for the initial or continuing validity of a permit to accept deposits, a provisional certificate of authority, or a certificate of authority. A condition may limit the circumstances under which the provider may enter into any new deposit agreement or contract, or may be imposed as a condition precedent to the issuance of a permit to accept deposits, a provisional certificate of authority, or a certificate of authority.

(7) "Consideration" means some right, interest, profit, or benefit paid, transferred, promised, or provided by one party to another as an inducement to contract. Consideration includes some forbearance, detriment, loss, or responsibility, that is given, suffered, or undertaken by a party as an inducement to another party to contract.

(8) "Continuing care contract" means a contract that includes a continuing care promise made, in exchange for an entrance fee, the payment of periodic charges, or both types of payments. A continuing care contract may consist of one agreement or a series of agreements and other writings incorporated by reference.

~~(9) "Continuing care advisory committee" means an advisory panel appointed pursuant to Section 1777.~~

~~(10)~~

(9) "Continuing care promise" means a promise, expressed or implied, by a provider to provide one or more elements of care to an elderly resident for the duration of his or her life or for a term in excess of one year. Any such promise or representation, whether part of a continuing care contract, other agreement, or series of agreements, or contained in any advertisement, brochure, or other material, either written or oral, is a continuing care promise.

~~(11)~~

(10) "Continuing care retirement community" means a facility located within the State of California where services promised in a continuing care contract are provided. A distinct phase of development approved by the department may be considered to be the continuing care retirement community when a project is being developed in successive distinct phases over a period of time. When the services are provided in residents' own homes, the

homes into which the provider takes those services are considered part of the continuing care retirement community.

~~(12)~~

(11) "Control" means directing or causing the direction of the financial management or the policies of another entity, including an operator of a continuing care retirement community, whether by means of the controlling entity's ownership interest, contract, or any other involvement. A parent entity or sole member of an entity controls a subsidiary entity provider for a continuing care retirement community if its officers, directors, or agents directly participate in the management of the subsidiary entity or in the initiation or approval of policies that affect the continuing care retirement community's operations, including, but not limited to, approving budgets or the administrator for a continuing care retirement community.

(d) (1) "Department" means the State Department of Social Services.

(2) "Deposit" means any transfer of consideration, including a promise to transfer money or property, made by a depositor to any entity that promises or proposes to promise to provide continuing care, but is not authorized to enter into a continuing care contract with the potential depositor.

(3) "Deposit agreement" means any agreement made between any entity accepting a deposit and a depositor. Deposit agreements for deposits received by an applicant prior to the department's release of funds from the deposit escrow account shall be subject to the requirements described in Section 1780.4.

(4) "Depository" means a bank or institution that is a member of the Federal Deposit Insurance Corporation or a comparable deposit insurance program.

(5) "Depositor" means any prospective resident who pays a deposit. Where any portion of the consideration transferred to an applicant as a deposit or to a provider as consideration for a continuing care contract is transferred by a person other than the prospective resident or a resident, that third-party transferor shall have the same cancellation or refund rights as the prospective resident or resident for whose benefit the consideration was transferred.

(6) "Director" means the Director of Social Services.

(e) (1) "Elderly" means an individual who is 60 years of age or older.

(2) "Entity" means an individual, partnership, corporation, limited liability company, and any other form for doing business. Entity includes a person, sole proprietorship, estate, trust, association, and joint venture.

(3) "Entrance fee" means the sum of any initial, amortized, or deferred transfer of consideration made or promised to be made by, or on behalf of, a person entering into a continuing care contract for the purpose of ensuring care or related services pursuant to that continuing care contract or as full or partial payment for the promise to provide care for the term of the continuing care contract. Entrance fee includes the purchase price of a condominium, cooperative, or other interest sold in connection with a promise of continuing care. An initial, amortized, or deferred transfer of consideration that is greater in value than 12 times the monthly care fee shall be presumed to be an entrance fee.

(4) "Equity" means the value of real property in excess of the aggregate amount of all liabilities secured by the property.

(5) "Equity interest" means an interest held by a resident in a continuing care retirement community that consists of either an ownership interest in any part of the continuing care retirement community property or a transferable membership that entitles the holder to reside at the continuing care retirement community.

(6) "Equity project" means a continuing care retirement community where residents receive an equity interest in the continuing care retirement community property.

(7) "Equity securities" shall refer generally to large and midcapitalization corporate stocks that are publicly traded and readily liquidated for cash, and shall include shares in mutual funds that hold portfolios consisting predominantly of these stocks and other qualifying assets, as defined by Section 1792.2. Equity securities shall also include other similar securities that are specifically approved by the department.

(8) "Escrow agent" means a bank or institution, including, but not limited to, a title insurance company, approved by the department to hold and render accountings for deposits of cash or cash equivalents.

(f) "Facility" means any place or accommodation where a provider provides or will provide a resident with care or related

services, whether or not the place or accommodation is constructed, owned, leased, rented, or otherwise contracted for by the provider.

(g) (reserved)

(h) (reserved)

(i) (1) "Inactive certificate of authority" means a certificate that has been terminated under Section 1793.8.

(2) "Investment securities" means any of the following:

(A) Direct obligations of the United States, including obligations issued or held in book-entry form on the books of the United States Department of the Treasury or obligations the timely payment of the principal of, and the interest on, which are fully guaranteed by the United States.

(B) Obligations, debentures, notes, or other evidences of indebtedness issued or guaranteed by any of the following:

(i) The Federal Home Loan Bank System.

(ii) The Export-Import Bank of the United States.

(iii) The Federal Financing Bank.

(iv) The Government National Mortgage Association.

(v) The Farmer's Home Administration.

(vi) The Federal Home Loan Mortgage Corporation of the Federal Housing Administration.

(vii) Any agency, department, or other instrumentality of the United States if the obligations are rated in one of the two highest rating categories of each rating agency rating those obligations.

(C) Bonds of the State of California or of any county, city and county, or city in this state, if rated in one of the two highest rating categories of each rating agency rating those bonds.

(D) Commercial paper of finance companies and banking institutions rated in one of the two highest categories of each rating agency rating those instruments.

(E) Repurchase agreements fully secured by collateral security described in subparagraph (A) or (B), as evidenced by an opinion of counsel, if the collateral is held by the provider or a third party during the term of the repurchase agreement, pursuant to the terms of the agreement, subject to liens or claims of third parties, and has a market value, which is determined at least every 14 days, at least equal to the amount so invested.

(F) Long-term investment agreements, which have maturity dates in excess of one year, with financial institutions, including, but not limited to, banks and insurance companies or their affiliates,

if the financial institution's paying ability for debt obligations or long-term claims or the paying ability of a related guarantor of the financial institution for these obligations or claims, is rated in one of the two highest rating categories of each rating agency rating those instruments, or if the short-term investment agreements are with the financial institution or the related guarantor of the financial institution, the long-term or short-term debt obligations, whichever is applicable, of which are rated in one of the two highest long-term or short-term rating categories, of each rating agency rating the bonds of the financial institution or the related guarantor, provided that if the rating falls below the two highest rating categories, the investment agreement shall allow the provider the option to replace the financial institution or the related guarantor of the financial institution or shall provide for the investment securities to be fully collateralized by investments described in subparagraph (A), and, provided further, if so collateralized, that the provider has a perfected first security lien on the collateral, as evidenced by an opinion of counsel and the collateral is held by the provider.

(G) Banker's acceptances or certificates of deposit of, or time deposits in, any savings and loan association that meets any of the following criteria:

(i) The debt obligations of the savings and loan association, or in the case of a principal bank, of the bank holding company, are rated in one of the two highest rating categories of each rating agency rating those instruments.

(ii) The certificates of deposit or time deposits are fully insured by the Federal Deposit Insurance Corporation.

(iii) The certificates of deposit or time deposits are secured at all times, in the manner and to the extent provided by law, by collateral security described in subparagraph (A) or (B) with a market value, valued at least quarterly, of no less than the original amount of moneys so invested.

(H) Taxable money market government portfolios restricted to obligations issued or guaranteed as to payment of principal and interest by the full faith and credit of the United States.

(I) Obligations the interest on which is excluded from gross income for federal income tax purposes and money market mutual funds whose portfolios are restricted to these obligations, if the obligations or mutual funds are rated in one of the two highest rating categories by each rating agency rating those obligations.

(J) Bonds that are not issued by the United States or any federal agency, but that are listed on a national exchange and that are rated at least "A" by Moody's Investors Service, or the equivalent rating by Standard and Poor's Corporation or Fitch Investors Service.

(K) Bonds not listed on a national exchange that are traded on an over-the-counter basis, and that are rated at least "Aa" by Moody's Investors Service or "AA" by Standard and Poor's Corporation or Fitch Investors Service.

(j) (reserved)

(k) (reserved)

(*l*) "Life care contract" means a continuing care contract that includes a promise, expressed or implied, by a provider to provide or pay for routine services at all levels of care, including acute care and the services of physicians and surgeons, to the extent not covered by other public or private insurance benefits, to a resident for the duration of his or her life. Care shall be provided under a life care contract in a continuing care retirement community having a comprehensive continuum of care, including a skilled nursing facility, under the ownership and supervision of the provider on or adjacent to the premises. No change may be made in the monthly fee based on level of care. A life care contract shall also include provisions to subsidize residents who become financially unable to pay their monthly care fees.

(m) (1) "Monthly care fee" means the fee charged to a resident in a continuing care contract on a monthly or other periodic basis for current accommodations and services including care, board, or lodging. Periodic entrance fee payments or other prepayments shall not be monthly care fees.

(2) "Monthly fee contract" means a continuing care contract that requires residents to pay monthly care fees.

(n) "Nonambulatory person" means a person who is unable to leave a building unassisted under emergency conditions in the manner described by Section 13131.

(o) (reserved)

(p) (1) "Per capita cost" means a continuing care retirement community's operating expenses, excluding depreciation, divided by the average number of residents.

(2) "Periodic charges" means fees paid by a resident on a periodic basis.

(3) "Permanent closure" means the voluntary or involuntary termination or forfeiture, as specified in subdivisions (a), (b), (g), (h), and (i) of Section 1793.7, of a provider's certificate of authority or license, or another action that results in the permanent relocation of residents. Permanent closure does not apply in the case of a natural disaster or other event out of the provider's control.

(4) "Permit to accept deposits" means a written authorization by the department permitting an applicant to enter into deposit agreements regarding a single specified continuing care retirement community.

(5) "Prepaid contract" means a continuing care contract in which the monthly care fee, if any, may not be adjusted to cover the actual cost of care and services.

(6) "Preferred access" means that residents who have previously occupied a residential living unit have a right over other persons to any assisted living or skilled nursing beds that are available at the community.

(7) "Processing fee" means a payment to cover administrative costs of processing the application of a depositor or prospective resident.

(8) "Promise to provide one or more elements of care" means any expressed or implied representation that one or more elements of care will be provided or will be available, such as by preferred access.

(9) "Proposes" means a representation that an applicant or provider will or intends to make a future promise to provide care, including a promise that is subject to a condition, such as the construction of a continuing care retirement community or the acquisition of a certificate of authority.

(10) "Provider" means an entity that provides continuing care, makes a continuing care promise, or proposes to promise to provide continuing care. "Provider" also includes any entity that controls an entity that provides continuing care, makes a continuing care promise, or proposes to promise to provide continuing care. The department shall determine whether an entity controls another entity for purposes of this article. No homeowner's association, cooperative, or condominium association may be a provider.

(11) "Provisional certificate of authority" means the certificate issued by the department, properly executed and bearing the State Seal, under Section 1786. A provisional certificate of authority

shall be limited to the specific continuing care retirement community and number of units identified in the applicant's application.

(q) (reserved)

(r) (1) "Refund reserve" means the reserve a provider is required to maintain, as provided in Section 1792.6.

(2) "Refundable contract" means a continuing care contract that includes a promise, expressed or implied, by the provider to pay an entrance fee refund or to repurchase the transferor's unit, membership, stock, or other interest in the continuing care retirement community when the promise to refund some or all of the initial entrance fee extends beyond the resident's sixth year of residency. Providers that enter into refundable contracts shall be subject to the refund reserve requirements of Section 1792.6. A continuing care contract that includes a promise to repay all or a portion of an entrance fee that is conditioned upon reoccupancy or resale of the unit previously occupied by the resident shall not be considered a refundable contract for purposes of the refund reserve requirements of Section 1792.6, provided that this conditional promise of repayment is not referred to by the applicant or provider as a "refund."

(3) "Resale fee" means a levy by the provider against the proceeds from the sale of a transferor's equity interest.

(4) "Reservation fee" refers to consideration collected by an entity that has made a continuing care promise or is proposing to make this promise and has complied with Section 1771.4.

(5) "Resident" means a person who enters into a continuing care contract with a provider, or who is designated in a continuing care contract to be a person being provided or to be provided services, including care, board, or lodging.

(6) "Residential care facility for the elderly" means a housing arrangement as defined by Section 1569.2.

(7) "Residential living unit" means a living unit in a continuing care retirement community that is not used exclusively for assisted living services or nursing services.

(8) "Residential temporary relocation" means the relocation of one or more residents, except in the case of a natural disaster that is out of the provider's control, from one or more residential living units, assisted living units, skilled nursing units, or a wing, floor, or entire continuing care retirement community building, due to a

change of use or major repairs or renovations. A residential temporary relocation shall mean a relocation pursuant to this subdivision that lasts for a period of at least nine months but that does not exceed 18 months without the written agreement of the resident.

(s) (reserved)

(t) (1) "Termination" means the ending of a continuing care contract as provided for in the terms of the continuing care contract.

(2) "Transfer trauma" means death, depression, or regressive behavior, that is caused by the abrupt and involuntary transfer of an elderly resident from one home to another and results from a loss of familiar physical environment, loss of well-known neighbors, attendants, nurses and medical personnel, the stress of an abrupt break in the small routines of daily life, or the loss of visits from friends and relatives who may be unable to reach the new facility.

(3) "Transferor" means a person who transfers, or promises to transfer, consideration in exchange for care and related services under a continuing care contract or proposed continuing care contract, for the benefit of another. A transferor shall have the same rights to cancel and obtain a refund as the depositor under the deposit agreement or the resident under a continuing care contract.

SEC. 5. Section 1771.7 of the Health and Safety Code is amended to read:

1771.7. (a) No resident of a continuing care retirement community shall be deprived of any civil or legal right, benefit, or privilege guaranteed by law, by the California Constitution, or by the United States Constitution, solely by reason of status as a resident of a community. In addition, because of the discretely different character of residential living unit programs that are a part of continuing care retirement communities, this section shall augment Chapter 3.9 (commencing with Section 1599), Sections 72527 and 87572 of Title 22 of the California Code of Regulations, and other applicable state and federal law and regulations.

(b) A prospective resident shall have the right to visit each of the different care levels and to inspect assisted living and skilled nursing home licensing reports including, but not limited to, the most recent inspection reports and findings of complaint

investigations covering a period of no less than two years, prior to signing a continuing care contract.

(c) All residents in residential living units shall have all of the following rights:

(1) To live in an attractive, safe, and well maintained physical environment.

(2) To live in an environment that enhances personal dignity, maintains independence, and encourages self-determination.

(3) To participate in activities that meet individual physical, intellectual, social, and spiritual needs.

(4) To expect effective channels of communication between residents and staff, and between residents and the administration or provider's governing body.

(5) To receive a clear and complete written contract that establishes the mutual rights and obligations of the resident and the continuing care retirement community.

(6) To manage his or her financial affairs.

(7) To be assured that all donations, contributions, gifts, or purchases of provider-sponsored financial products shall be voluntary, and may not be a condition of acceptance or of ongoing eligibility for services.

(8) To maintain and establish ties to the local community.

(9) To organize and participate freely in the operation of independent resident organizations and associations.

(d) A continuing care retirement community shall maintain an environment that enhances the residents' self-determination and independence. The provider shall do both of the following:

(1) Encourage the formation of a resident association by interested residents who may elect a governing body. The provider shall provide space and post notices for meetings, and provide assistance in attending meetings for those residents who request it. In order to promote a free exchange of ideas, at least part of each meeting shall be conducted without the presence of any continuing care retirement community personnel. The association may, among other things, make recommendations to management regarding resident issues that impact the residents' quality of life, quality of care, exercise of rights, safety and quality of the physical environment, concerns about the contract, fiscal matters, or other issues of concern to residents. The management shall respond, in writing, to a written request or concern of the resident association

within 20 working days of receiving the written request or concern. Meetings shall be open to all residents to attend as well as to present issues. Executive sessions of the governing body shall be attended only by the governing body.

(2) Establish policies and procedures that promote the sharing of information, dialogue between residents and management, and access to the provider's governing body. The provider shall biennially conduct a resident satisfaction survey that shall be made available to the resident association or its governing body, or, if neither exists, to a committee of residents at least 14 days prior to the next semiannual meeting of residents and the governing board of the provider required by subdivision (c) of Section 1771.8. A copy of the survey shall be posted in a conspicuous location at each facility.

(e) In addition to any statutory or regulatory bill of rights required to be provided to residents of residential care facilities for the elderly or skilled nursing facilities, the provider shall provide a copy of the bill of rights prescribed by this section to each resident at the time or before the resident signs a continuing care contract, and at any time when the resident is proposed to be moved to a different level of care.

(f) Each continuing care retirement community shall prominently post in areas accessible to the residents and visitors a notice that a copy of rights applicable to residents pursuant to this section and any governing regulation issued by the Continuing Care Contracts Branch of the State Department of Social Services is available upon request from the provider. The notice shall also state that the residents have a right to file a complaint with the Continuing Care Contracts Branch for any violation of those rights and shall contain information explaining how a complaint may be filed, including the telephone number and address of the Continuing Care Contracts Branch.

(g) The resident has the right to freely exercise all rights pursuant to this section, in addition to political rights, without retaliation by the provider.

(h) The department may, upon receiving a complaint of a violation of this section, request a copy of the policies and procedures along with documentation on the conduct and findings of any self-evaluations ~~and consult with the Continuing Care Advisory Committee for determination of compliance~~.

(i) Failure to comply with this section shall be grounds for the imposition of conditions on, suspension of, or revocation of the provisional certificate of authority or certificate of authority pursuant to Section 1793.21.

(j) Failure to comply with this section constitutes a violation of residents' rights. Pursuant to Section 1569.49 of the Health and Safety Code, the department shall impose and collect a civil penalty of not more than one hundred fifty dollars ($150) per violation upon a continuing care retirement community that violates a right guaranteed by this section.

SEC. 6. Section 1771.8 of the Health and Safety Code is amended to read:

1771.8. (a) The Legislature finds and declares all of the following:

(1) The residents of continuing care retirement communities have a unique and valuable perspective on the operations of and services provided in the community in which they live.

(2) Resident input into decisions made by the provider is an important factor in creating an environment of cooperation, reducing conflict, and ensuring timely response and resolution to issues that may arise.

(3) Continuing care retirement communities are strengthened when residents know that their views are heard and respected.

(b) The Legislature encourages continuing care retirement communities to exceed the minimum resident participation requirements established by this section by, among other things, the following:

(1) Encouraging residents to form a resident association, and assisting the residents, the resident association, and its governing body to keep informed about the operation of the continuing care retirement community.

(2) Encouraging residents of a continuing care retirement community or their elected representatives to select residents to participate as board members of the governing body of the provider.

(3) Quickly and fairly resolving any dispute, claim, or grievance arising between a resident and the continuing care retirement community.

(c) The governing body of a provider, or the designated representative of the provider, shall hold, at a minimum,

semiannual meetings with the residents of the continuing care retirement community, or the resident association or its governing body, for the purpose of the free discussion of subjects including, but not limited to, income, expenditures, and financial trends and issues as they apply to the continuing care retirement community and proposed changes in policies, programs, and services. Nothing in this section precludes a provider from taking action or making a decision at any time, without regard to the meetings required under this subdivision.

(d) At least 30 days prior to the implementation of any increase in the monthly care fee, the designated representative of the provider shall convene a meeting, to which all residents shall be invited, for the purpose of discussing the reasons for the increase, the basis for determining the amount of the increase, and the data used for calculating the increase. This meeting may coincide with the semiannual meetings provided for in subdivision (c). At least 14 days prior to the meeting to discuss any increase in the monthly care fee, the provider shall make available to each resident or resident household comparative data showing the budget for the upcoming year, the current year's budget, and actual and projected expenses for the current year, and a copy shall be posted in a conspicuous location at each facility.

(e) The governing body of a provider or the designated representative of the provider shall provide residents with at least 14 days' advance notice of each meeting provided for in subdivisions (c) and (d), and shall permit residents attending the meeting to present issues orally and in writing. The governing body of a provider or the designated representative of the provider shall post the notice of, and the agenda for, the meeting in a conspicuous place in the continuing care retirement community at least 14 days prior to the meeting. The governing body of a provider or the designated representative of the provider shall make available to residents of the continuing care retirement community upon request the agenda and accompanying materials at least seven days prior to the meeting.

(f) Each provider shall make available to the resident association or its governing body, or if neither exists, to a committee of residents, a financial statement of activities for that facility comparing actual costs to budgeted costs broken down by expense category, not less than semiannually, and shall consult with the

resident association or its governing body, or, if neither exists, with a committee of residents, during the annual budget planning process. The effectiveness of consultations during the annual budget planning process shall be evaluated at a minimum every two years by the continuing care retirement community administration. The evaluation, including any policies adopted relating to cooperation with residents, shall be made available to the resident association or its governing body, or, if neither exists, to a committee of residents at least 14 days prior to the next semiannual meeting of residents and the provider's governing body provided for in subdivision (c), and a copy of the evaluation shall be posted in a conspicuous location at each facility.

(g) Each provider shall, within 10 days after the annual report required pursuant to Section 1790 is submitted to the department, provide, at a central and conspicuous location in the community, a copy of the annual report, including the multifacility statement of activities, and including a copy of the annual audited financial statement, but excluding personal confidential information.

(h) Each provider shall maintain, as public information, available upon request to residents, prospective residents, and the public, minutes of the board of director's meetings and shall retain these records for at least three years from the date the records were filed or issued.

(i) The governing body of a provider that is not part of a multifacility organization with more than one continuing care retirement community in the state shall accept at least one resident of the continuing care retirement community it operates to participate as a nonvoting resident representative to the provider's governing body.

(j) In a multifacility organization having more than one continuing care retirement community in the state, the governing body of the multifacility organization shall elect either to have at least one nonvoting resident representative to the provider's governing body for each California-based continuing care retirement community the provider operates or to have a resident-elected committee composed of representatives of the residents of each California-based continuing care retirement community that the provider operates select or nominate at least one nonvoting resident representative to the provider's governing body for every three California-based continuing care retirement

communities or fraction thereof that the provider operates. If a multifacility organization elects to have one representative for every three communities that the provider operates, the provider shall provide to the president of the residents association of each of the communities that do not have a resident representative, the same notice of board meetings, board packets, minutes, and other materials as the resident representative. At the reasonable discretion of the provider, information related to litigation, personnel, competitive advantage, or confidential information that is not appropriate to disclose, may be withheld.

(k) In order to encourage innovative and alternative models of resident involvement, a resident selected pursuant to subdivision (i) to participate as a resident representative to the provider's governing body may, at the option of the resident association, be selected in any one of the following ways:

(1) By a majority vote of the resident association of a provider or by a majority vote of a resident-elected committee of residents of a multifacility organization.

(2) If no resident association exists, any resident may organize a meeting of the majority of the residents of the continuing care retirement community to select or nominate residents to represent them before the governing body.

(3) Any other method designated by the resident association.

(*l*) The resident association, or organizing resident, or in the case of a multifacility organization, the resident-elected committee of residents, shall give residents of the continuing care retirement community at least 30 days' advance notice of the meeting to select a resident representative and shall post the notice in a conspicuous place at the continuing care retirement community.

(m) (1) Except as provided in subdivision (n), the resident representative shall receive the same notice of board meetings, board packets, minutes, and other materials as members and shall be permitted to attend, speak, and participate in all meetings of the board.

(2) Resident representatives may share information from board meetings with other residents, unless the information is confidential or doing so would violate fiduciary duties to the provider. In addition, a resident representative shall be permitted to attend meetings of the board committee or committees that review the annual budget of the facility or facilities and recommend increases

in monthly care fees. The resident shall receive the same notice of committee meetings, information packets, minutes, and other materials as committee members, and shall be permitted to attend, speak at, and participate in, committee meetings. Resident representatives shall perform their duties in good faith and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under similar circumstances.

(n) Notwithstanding subdivision (m), the governing body may exclude resident representatives from its executive sessions and from receiving board materials to be discussed during executive session. However, resident representatives shall be included in executive sessions and shall receive all board materials to be discussed during executive sessions related to discussions of the annual budgets, increases in monthly care fees, indebtedness, and expansion of new and existing continuing care retirement communities.

(o) The provider shall pay all reasonable travel costs for the resident representative.

(p) The provider shall disclose in writing the extent of resident involvement with the board to prospective residents.

(q) Nothing in this section prohibits a provider from exceeding the minimum resident participation requirements of this section by, for example, having more resident meetings or more resident representatives to the board than required or by having one or more residents on the provider's governing body who are selected with the active involvement of residents.

(r) On or before April 1, 2003, the department~~, with input from the Continuing Care Advisory Committee of the department established pursuant to Section 1777,~~ shall do all of the following:

(1) Make recommendations to the Legislature as to whether any changes in current law regarding resident representation to the board is needed.

(2) Provide written guidelines available to residents and providers that address issues related to board participation, including rights and responsibilities, and that provide guidance on the extent to which resident representatives who are not voting members of the board have a duty of care, loyalty, and obedience to the provider and the extent to which providers can classify information as confidential and not subject to disclosure by resident representatives to other residents.

SEC. 7. Section 1776.3 of the Health and Safety Code is amended to read:

1776.3. (a) The Continuing Care Contracts Branch of the department shall enter and review each continuing care retirement community in the state at least once every three years to augment the branch's assessment of the provider's financial soundness.

(b) During its facility visits, the branch shall consider the condition of the facility, whether the facility is operating in compliance with applicable state law, and whether the provider is performing the services it has specified in its continuing care contracts.

(c) The branch shall issue guidelines that require each provider to adopt a comprehensive disaster preparedness plan, update that plan at least every three years, submit a copy to the department, and make copies available to residents in a prominent location in each continuing care retirement community facility.

(d) (1) The branch shall respond within 15 business days to residents' rights, service-related, and financially related complaints by residents, and shall furnish to residents upon request and within 15 business days any document or report filed with the department by a continuing care provider, except documents protected by privacy laws.

(2) ~~The branch shall provide the Continuing Care Contracts Advisory Committee with a summary of all residents' rights, service-related, and financially related complaints by residents.~~ The provider shall disclose any citation issued by the department pursuant to Section 1793.6 in its disclosure statement to residents as updated annually, and shall post a notice of the citation in a conspicuous location in the facility. The notice shall include a statement indicating that residents may obtain additional information regarding the citation from the provider and the department.

~~(e) The branch shall annually review, summarize, and report to the director on the work of the Continuing Care Contracts Advisory Committee, including any issues arising from its review of the condition of any continuing care retirement community or any continuing care retirement community provider, and including any recommendations for actions by the committee, the department, or the Legislature to improve oversight of continuing care retirement community.~~

SEC. 8. Section 1777 of the Health and Safety Code is repealed.

~~1777. (a) The Continuing Care Advisory Committee of the department shall act in an advisory capacity to the department on matters relating to continuing care contracts.~~

~~(b) The members of the committee shall include:~~

~~(1) Three representatives of nonprofit continuing care providers pursuant to this chapter, each of whom shall have offered continuing care services for at least five years prior to appointment. One member shall represent a multifacility provider and shall be appointed by the Governor in even years. One member shall be appointed by the Senate Committee on Rules in odd years. One member shall be appointed by the Speaker of the Assembly in odd years.~~

~~(2) Three senior citizens who are not eligible for appointment pursuant to paragraphs (1) and (4) who shall represent consumers of continuing care services, all of whom shall be residents of continuing care retirement communities but not residents of the same provider. One senior citizen member shall be appointed by the Governor in even years. One senior citizen member shall be appointed by the Senate Committee on Rules in odd years. One senior citizen member shall be appointed by the Speaker of the Assembly in odd years.~~

~~(3) A certified public accountant with experience in the continuing care industry, who is not a provider of continuing care services. This member shall be appointed by the Governor in even years.~~

~~(4) A representative of a for-profit provider of continuing care contracts pursuant to this chapter. This member shall be appointed by the Governor in even years.~~

~~(5) An actuary. This member shall be appointed by the Governor in even years.~~

~~(6) One representative of residents of continuing care retirement communities appointed by the senior citizen representatives on the committee.~~

~~(7) One representative of either nonprofit or for-profit providers appointed by the representatives of nonprofit and for-provider providers on the committee.~~

~~(c) Commencing January 1, 1997, all members shall serve two-year terms and be appointed based on their interest and expertise in the subject area. The Governor shall designate the~~

~~chairperson for the committee with the advice and consent of the Senate. A member may be reappointed at the pleasure of the appointing power. The appointing power shall fill all vacancies on the committee within 60 days. All members shall continue to serve until their successors are appointed and qualified.~~

~~(d) The members of the committee shall serve without compensation, except that each member shall be paid from the Continuing Care Provider Fee Fund a per diem of twenty-five dollars ($25) for each day's attendance at a meeting of the committee not to exceed six days in any month. The members of the committee shall also receive their actual and necessary travel expenses incurred in the course of their duties. Reimbursement of travel expenses shall be at rates not to exceed those applicable to comparable state employees under Department of Personnel Administration regulations.~~

~~(e) Prior to commencement of service, each member shall file with the department a statement of economic interest and a statement of conflict of interest pursuant to Article 3 (commencing with Section 87300) of the Government Code.~~

~~(f) If, during the period of appointment, any member no longer meets the qualifications of subdivision (b), that member shall submit his or her resignation to their appointing power and a qualified new member shall be appointed by the same power to fulfill the remainder of the term.~~

~~(g) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.~~

SEC. 9. Section 1777.2 of the Health and Safety Code is repealed.

~~1777.2. (a) The Continuing Care Advisory Committee shall:~~

~~(1) Review the financial and managerial condition of continuing care retirement communities operating under a certificate of authority.~~

~~(2) Review the financial condition of any continuing care retirement community that the committee determines is indicating signs of financial difficulty and may be in need of close supervision.~~

~~(3) Monitor the condition of those continuing care retirement communities that the department or the chair of the committee may request.~~

~~(4) Make available consumer information on the selection of continuing care contracts and necessary contract protections in the purchase of continuing care contracts.~~

~~(5) Review new applications regarding financial, actuarial, and marketing feasibility as requested by the department.~~

~~(b) The committee shall make recommendations to the department regarding needed changes in its rules and regulations and upon request provide advice regarding the feasibility of new continuing care retirement communities and the correction of problems relating to the management or operation of any continuing care retirement community. The committee shall also perform any other advisory functions necessary to improve the management and operation of continuing care retirement communities.~~

~~(c) The committee may report on its recommendations directly to the director of the department.~~

~~(d) The committee may hold meetings, as deemed necessary to the performance of its duties.~~

~~(e) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.~~

SEC. 10. Section 1777.4 of the Health and Safety Code is repealed.

~~1777.4. (a) Any member of the Continuing Care Advisory Committee is immune from civil liability based on acts performed in his or her official capacity. Costs of defending civil actions brought against a member for acts performed in his or her official capacity shall be borne by the complainant. However, nothing in this section immunizes any member for acts or omissions performed with malice or in bad faith.~~

~~(b) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.~~

SEC. 11. Section 1783.3 of the Health and Safety Code is amended to read:

1783.3. (a) In order to seek a release of escrowed funds, the applicant shall petition in writing to the department and certify to each of the following:

(1) The construction of the proposed continuing care retirement community or phase is at least 50 percent completed.

(2) At least 10 percent of the total of each applicable entrance fee has been received and placed in escrow for at least 60 percent of the total number of residential living units. Any unit for which a refund is pending may not be counted toward that 60-percent requirement.

(3) Deposits made with cash equivalents have been either converted into, or substituted with, cash or held for transfer to the provider. A cash equivalent deposit may be held for transfer to the provider, if all of the following conditions exist:

(A) Conversion of the cash equivalent instrument would result in a penalty or other substantial detriment to the depositor.

(B) The provider and the depositor have a written agreement stating that the cash equivalent will be transferred to the provider, without conversion into cash, when the deposit escrow is released to the provider under this section.

(C) The depositor is credited the amount equal to the value of the cash equivalent.

(4) The applicant's average performance over any six-month period substantially equals or exceeds its financial and marketing projections approved by the department, for that period.

(5) The applicant has received a commitment for any permanent mortgage loan or other long-term financing.

(b) The department shall instruct the escrow agent to release to the applicant all deposits in the deposit escrow account when all of the following requirements have been met:

(1) The department has confirmed the information provided by the applicant pursuant to subdivision (a).

(2) The department~~, in consultation with the Continuing Care Advisory Committee,~~ has determined that there has been substantial compliance with projected annual financial statements that served as a basis for issuance of the permit to accept deposits.

(3) The applicant has complied with all applicable licensing requirements in a timely manner.

(4) The applicant has obtained a commitment for any permanent mortgage loan or other long-term financing that is satisfactory to the department.

(5) The applicant has complied with any additional reasonable requirements for release of funds placed in the deposit escrow accounts, established by the department under Section 1785.

(c) The escrow agent shall release the funds held in escrow to the applicant only when the department has instructed it to do so in writing.

(d) When an application describes different phases of construction that will be completed and commence operating at different times, the department may apply the 50 percent construction completion requirement to any one or group of phases requested by the applicant, provided the phase or group of phases is shown in the applicant's projections to be economically viable.

SEC. 12. Section 1785 of the Health and Safety Code is amended to read:

1785. (a) If, at any time prior to issuance of a certificate of authority, the applicant's average performance over any six-month period does not substantially equal or exceed the applicant's projections for that period, the department~~, after consultation and upon consideration of the recommendations of the Continuing Care Advisory Committee,~~ may take any of the following actions:

(1) Cancel the permit to accept deposits and require that all funds in escrow be returned to depositors immediately.

(2) Increase the required percentages of construction completed, units reserved, or entrance fees to be deposited as required under Sections 1782, 1783.3, 1786, and 1786.2.

(3) Increase the reserve requirements under this chapter.

(b) Prior to taking any actions specified in subdivision (a), the department shall give the applicant an opportunity to submit a feasibility study from a consultant in the area of continuing care, approved by the department, to determine whether in his or her opinion the proposed continuing care retirement community is still viable, and if so, to submit a plan of correction. The department~~, in consultation with the committee,~~ shall determine if the plan is acceptable.

(c) In making its determination, the department shall take into consideration the overall performance of the proposed continuing care retirement community to date.

(d) If deposits have been released from escrow, the department may further require the applicant to reopen the escrow as a condition of receiving any further entrance fee payments from depositors or residents.

(e) The department may require the applicant to notify all depositors and, if applicable, all residents, of any actions required by the department under this section.

SEC. 13. Section 1793.13 of the Health and Safety Code is amended to read:

1793.13. (a) The department may require a provider to submit a financial plan, if either of the following applies:

(1) A provider fails to file a complete annual report as required by Section 1790.

(2) The department has reason to believe that the provider is insolvent, is in imminent danger of becoming insolvent, is in a financially unsound or unsafe condition, or that its condition is such that it may otherwise be unable to fully perform its obligations pursuant to continuing care contracts.

(b) A provider shall submit its financial plan to the department within 60 days following the date of the department's request. The financial plan shall explain how and when the provider will rectify the problems and deficiencies identified by the department.

(c) The department shall approve or disapprove the plan within 30 days of its receipt.

(d) If the plan is approved, the provider shall immediately implement the plan.

(e) If the plan is disapproved, or if it is determined that the plan is not being fully implemented, the department may~~, after consultation with and upon consideration of the recommendations of the Continuing Care Advisory Committee~~, consult with its financial consultants to develop a corrective action plan at the provider's expense, or require the provider to obtain new or additional management capability approved by the department to solve its difficulties. A reasonable period, as determined by the department, shall be allowed for the reorganized management to develop a plan which, subject to the approval of the department ~~and after review by the committee~~, will reasonably assure that the provider will meet its responsibilities under the law.

SEC. 14. Section 1793.23 of the Health and Safety Code is amended to read:

~~1793.23. (a) The department shall consult with and consider the recommendations of the Continuing Care Advisory Committee prior to conditioning, suspending, or revoking any permit to accept~~

~~deposits, provisional certificate of authority, or certificate of authority.~~

~~(b) The~~

1793.23. (a) If the department conditions, suspends, or revokes any permit to accept deposits, provisional certificate of authority, or certificate of authority issued pursuant to this chapter, the provider shall have a right of appeal to the department. The proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the department shall have all of the powers granted therein. A suspension, condition, or revocation shall remain in effect until completion of the proceedings in favor of the provider. In all proceedings conducted in accordance with this section, the standard of proof to be applied shall be by a preponderance of the evidence.

~~(c)~~

(b) The department may, upon finding of changed circumstances, remove a suspension or condition.

SEC. 15. Section 1793.50 of the Health and Safety Code is amended to read:

1793.50. (a) The department~~, after consultation with the Continuing Care Advisory Committee,~~ may petition the superior court for an order appointing a qualified administrator to operate a continuing care retirement community, and thereby mitigate imminent crisis situations where elderly residents could lose support services or be moved without proper preparation, in any of the following circumstances:

(1) The provider is insolvent or in imminent danger of becoming insolvent.

(2) The provider is in a financially unsound or unsafe condition.

(3) The provider has failed to establish or has substantially depleted the reserves required by this chapter.

(4) The provider has failed to submit a plan, as specified in Section 1793.13, the department has not approved the plan submitted by the provider, the provider has not fully implemented the plan, or the plan has not been successful.

(5) The provider is unable to fully perform its obligations pursuant to continuing care contracts.

(6) The residents are otherwise placed in serious jeopardy.

(b) The administrator may only assume the operation of the continuing care retirement community in order to accomplish one or more of the following: rehabilitate the provider to enable it fully to perform its continuing care contract obligations; implement a plan of reorganization acceptable to the department; facilitate the transition where another provider assumes continuing care contract obligations; or facilitate an orderly liquidation of the provider.

(c) With each petition, the department shall include a request for a temporary restraining order to prevent the provider from disposing of or transferring assets pending the hearing on the petition.

(d) The provider shall be served with a copy of the petition, together with an order to appear and show cause why management and possession of the provider's continuing care retirement community or assets should not be vested in an administrator.

(e) The order to show cause shall specify a hearing date, which shall be not less than five nor more than 10 days following service of the petition and order to show cause on the provider.

(f) Petitions to appoint an administrator shall have precedence over all matters, except criminal matters, in the court.

(g) At the time of the hearing, the department shall advise the provider and the court of the name of the proposed administrator.

(h) If, at the conclusion of the hearing, including such oral evidence as the court may consider, the court finds that any of the circumstances specified in subdivision (a) exist, the court shall issue an order appointing an administrator to take possession of the property of the provider and to conduct the business thereof, enjoining the provider from interfering with the administrator in the conduct of the rehabilitation, and directing the administrator to take steps toward removal of the causes and conditions which have made rehabilitation necessary, as the court may direct.

(i) The order shall include a provision directing the issuance of a notice of the rehabilitation proceedings to the residents at the continuing care retirement community and to other interested persons as the court may direct.

(j) The court may permit the provider to participate in the continued operation of the continuing care retirement community during the pendency of any appointments ordered pursuant to this section and shall specify in the order the nature and scope of the participation.

(k) The court shall retain jurisdiction throughout the rehabilitation proceeding and may issue further orders as it deems necessary to accomplish the rehabilitation or orderly liquidation of the continuing care retirement community in order to protect the residents of the continuing care retirement community.

SEC. 16. Section 1793.60 of the Health and Safety Code is amended to read:

1793.60. (a) If at any time the department determines that further efforts to rehabilitate the provider would not be in the best interest of the residents or prospective residents, or would not be economically feasible, the department may~~, with the approval of the Continuing Care Advisory Committee,~~ apply to the court for an order of liquidation and dissolution or may apply for other appropriate relief for dissolving the property and bringing to conclusion its business affairs.

(b) Upon issuance of an order directing the liquidation or dissolution of the provider, the department shall revoke the provider's provisional certificate of authority or certificate of authority.

SEC. 17. Section 127280 of the Health and Safety Code is amended to read:

127280. (a) Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the state, shall each year be charged a fee established by the office consistent with the requirements of this section.

(b) Commencing in calendar year 2004, every freestanding ambulatory surgery clinic as defined in Section 128700, shall each year be charged a fee established by the office consistent with the requirements of this section.

(c) The fee structure shall be established each year by the office to produce revenues equal to the appropriation made in the annual Budget Act or another statute to pay for the functions required to be performed by the office~~ and the California Health Policy and Data Advisory Commission~~ pursuant to this chapter, Article 2 (commencing with Section 127340) of Chapter 2, or Chapter 1 (commencing with Section 128675) of Part 5, and to pay for any other health-related programs administered by the office. The fee shall be due on July 1 and delinquent on July 31 of each year.

(d) The fee for a health facility that is not a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(e) The fee for a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(f) (1) The fee for a freestanding ambulatory surgery clinic shall be established at an amount equal to the number of ambulatory surgery data records submitted to the office pursuant to Section 128737 for encounters in the preceding calendar year multiplied by not more than fifty cents ($0.50).

(2) (A) For the calendar year 2004 only, a freestanding ambulatory surgery clinic shall estimate the number of records it will file pursuant to Section 128737 for the calendar year 2004 and shall report that number to the office by March 12, 2004. The estimate shall be as accurate as possible. The fee in the calendar year 2004 shall be established initially at an amount equal to the estimated number of records reported multiplied by fifty cents ($0.50) and shall be due on July 1 and delinquent on July 31, 2004.

(B) The office shall compare the actual number of records filed by each freestanding clinic for the calendar year 2004 pursuant to Section 128737 with the estimated number of records reported pursuant to subparagraph (A). If the actual number reported is less than the estimated number reported, the office shall reduce the fee of the clinic for calendar year 2005 by the amount of the difference multiplied by fifty cents ($0.50). If the actual number reported exceeds the estimated number reported, the office shall increase the fee of the clinic for calendar year 2005 by the amount of the difference multiplied by fifty cents ($0.50) unless the actual number reported is greater than 120 percent of the estimated number reported, in which case the office shall increase the fee of the clinic for calendar year 2005 by the amount of the difference, up to and including 120 percent of the estimated number, multiplied by fifty cents ($0.50), and by the amount of the difference in excess of 120 percent of the estimated number multiplied by one dollar ($1).

(g) There is hereby established the California Health Data and Planning Fund within the office for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(h) Any amounts raised by the collection of the special fees provided for by subdivisions (d), (e), and (f) that are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the office ~~and the commission~~ in succeeding years when appropriated by the Legislature in the annual Budget Act or another statute, for expenditure under the provisions of this chapter, Article 2 (commencing with Section 127340) of Chapter 2, and Chapter 1 (commencing with Section 128675) of Part 5, or for any other health-related programs administered by the office, and shall reduce the amount of the special fees that the office is authorized to establish and charge.

(i) (1) No health facility liable for the payment of fees required by this section shall be issued a license or have an existing license renewed unless the fees are paid. A new, previously unlicensed, health facility shall be charged a pro rata fee to be established by the office during the first year of operation.

(2) The license of any health facility, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the office that the fees required were not paid within the time prescribed by subdivision (c).

(j) This section shall become operative on January 1, 2002.

SEC. 18. Section 127670 of the Health and Safety Code is repealed.

~~127670. The Legislature finds and declares the following:~~

~~(a) California's health care system needs to be reformed to provide high quality accessible, affordable, and equitable care and treatment.~~

~~(b) Too many Californians are unable to obtain affordable, high quality health care.~~

~~(c) The rising costs associated with health care are driven by numerous factors, including, but not limited to, the following:~~

~~(1) Prescription drug spending, including costs of research and development and marketing and increased drug utilization.~~

~~(2) Hospital rates.~~

~~(3) Health insurance premium rates.~~

~~(4) Provider rates.~~

~~(5) Health system inefficiencies.~~

~~(6) Fraud and abuse in the health care system.~~

~~(7) Technology development and utilization.~~

~~(8) Emergency room overutilization.~~

~~(9) Inequitable allocation of services and treatment to different segments of the population.~~

~~(10) Cost shifting, which occurs when the costs of providing uncompensated health care to uninsured individuals is shifted to those with health insurance, driving health care prices and insurance premiums higher.~~

~~(d) Health care cost containment is an important part of enabling the health care coverage system to provide high quality care in a manner that improves patient outcomes.~~

~~(e) Evidence-based medicine may improve cost-effectiveness and care to patients by using scientific evidence to determine clinical practice, drug therapy, and other measures that improve the quality of care in a cost-effective manner while taking into account the special needs of individual patients. To improve quality as well as cost-effectiveness, evidence-based medicine should take into account the special needs of persons with disabilities as well as the racial, ethnic, and gender disparities in health research and the provision of health care.~~

~~(f) Chronic diseases, such as heart disease, stroke, asthma, cancer, and diabetes, are among the most prevalent, costly, and preventable of all health problems. Seventy-eight percent of health care costs can be attributed to the treatment of chronic conditions. "Disease management" provides a strategy to improve patient health outcomes and limit health care spending by identifying and monitoring high-risk populations, helping patients and providers better adhere to proven interventions, engaging patients in their own care management, and establishing more coordinated care interventions and followup systems to prevent unnecessary and expensive health complications. These disease management strategies should be tailored to fit the needs of each patient. Disease management is most effective when it takes into account racial, ethnic, and gender disparities in health research and the provision of health care.~~

~~(g) Without reform, California's health care system may fail to deliver the affordable quality care that all Californians deserve.~~

~~(h) It is the intent of the Legislature to make available valid performance information to encourage hospitals and physicians to provide care that is safe, medically effective, patient-centered, timely, efficient, and equitable. It is also the intent of the Legislature to strengthen the ability of the Office of Statewide Health Planning and Development to put hospital performance information into the hands of consumers, purchasers, and providers.~~

~~(i) It is the intent of the Legislature to encourage health care service plans, health insurers, and providers to develop innovative approaches, services, and programs that may have the potential to deliver health care that is both cost-effective and responsive to the needs of enrollees.~~

SEC. 19. Section 127671 of the Health and Safety Code is repealed.

~~127671. (a) The Governor shall convene the California Health Care Quality Improvement and Cost Containment Commission, hereinafter referred to as "the commission," to research and recommend appropriate and timely strategies for promoting high quality care and containing health care costs.~~

~~(b) The commission shall be composed of 27 members who are knowledgeable about the health care system and health care spending.~~

~~(c) The Governor shall appoint 17 members of the commission, as follows:~~

~~(1) Three representatives of California's business community, including at least one representative from a small business.~~

~~(2) Two representatives from organized labor, one of whom represents health care workers.~~

~~(3) Two representatives of consumers.~~

~~(4) Two health care practitioners, including at least one physician.~~

~~(5) One representative of the disabilities community.~~

~~(6) One hospital industry representative.~~

~~(7) One pharmaceutical industry representative.~~

~~(8) Two representatives of the health insurance industry, one with expertise in managed health care delivery systems and one with expertise in health insurance underwriting and rating.~~

~~(9) One representative of academic or health care policy research institutions.~~

~~(10) One health care economist.~~

~~(11) One expert in disease management techniques and wellness programs.~~

~~(d) The Senate Committee on Rules shall appoint four members, with two members from the majority party and two from the minority party.~~

~~(e) The Speaker of the Assembly shall appoint four members, of which two members shall be the Chair and Vice Chair of the Assembly Committee on Health.~~

~~(f) The Secretary of the Health and Human Services Agency and the Director of the Department of Managed Health Care shall serve as members of the commission.~~

~~(g) The Governor shall appoint the chairperson of the commission.~~

~~(h) The commission shall, on or before January 1, 2006, issue a report to the Legislature and the Governor making recommendations for health care quality improvement and cost containment. The commission shall, at a minimum, examine and address the following issues:~~

~~(1) Assessing California health care needs and available resources.~~

~~(2) Lowering the cost of health care coverage.~~

~~(3) Increasing patient choices of health coverage options and providers.~~

~~(4) Improving the quality of health care.~~

~~(5) Increasing the transparency of health care costs and the relative efficiency with which care is delivered.~~

~~(6) Potential for integration with workers' compensation insurance.~~

~~(7) Use of disease management, wellness, prevention, and other innovative programs to keep people healthy while reducing costs and improving health outcomes.~~

~~(8) Consolidation of existing state programs to achieve efficiencies where possible.~~

~~(9) Efficient utilization of prescription drugs and technology.~~

~~(i) Notwithstanding any other provision of law, the members of the task force shall receive no per diem or travel expense reimbursement, or any other expense reimbursement.~~

SEC. 20. Section 128680 of the Health and Safety Code is amended to read:

128680. The Legislature hereby finds and declares that:

(a) Significant changes have taken place in recent years in the health care marketplace and in the manner of reimbursement to health facilities by government and private third-party payers for the services they provide.

(b) These changes have permitted the state to reevaluate the need for, and the manner of data collection from health facilities by the various state agencies and commissions.

(c) It is the intent of the Legislature that as a result of this reevaluation that the data collection function be consolidated in a single state agency. It is the further intent of the Legislature that the single state agency only collect that data from health facilities that are essential. The data should be collected, to the extent practical on consolidated, multipurpose report forms for use by all state agencies.

(d) It is the further intent of the Legislature to eliminate the California Health Facilities Commission ~~and~~, the State Advisory Health Council, *and the California Health Policy and Data Advisory Commission*, and to ~~create a single advisory commission to assume consolidated~~ *consolidate* data collection and planning functions *within the office*.

(e) It is the Legislature's further intent that the review of the data that the state collects be an ongoing function. The office~~, with the advice of the advisory commission,~~ shall annually review this data for need and shall revise, add, or delete items as necessary. The ~~commission and the~~ office shall consult with affected state agencies and the affected industry when adding or eliminating data items. However, the office shall neither add nor delete data items to the Hospital Discharge Abstract Data Record or the quarterly reports without prior authorizing legislation, unless specifically required by federal law or judicial decision.

(f) The Legislature recognizes that the authority for the California Health Facilities Commission is scheduled to expire January 1, 1986. It is the intent of the Legislature, by the enactment of this chapter, to continue the uniform system of accounting and reporting established by the commission and required for use by health facilities. It is also the intent of the Legislature to continue an appropriate, cost-disclosure program.

SEC. 21. Section 128695 of the Health and Safety Code is repealed.

~~128695. There is hereby created the California Health Policy and Data Advisory Commission to be composed of 13 members.~~

~~The Governor shall appoint nine members, one of whom shall be a hospital chief executive officer, one of whom shall be a chief executive officer of a hospital serving a disproportionate share of low-income patients, one of whom shall be a long-term care facility chief executive officer, one of whom shall be a freestanding ambulatory surgery clinic chief executive officer, one of whom shall be a representative of the health insurance industry involved in establishing premiums or underwriting, one of whom shall be a representative of a group prepayment health care service plan, one of whom shall be a representative of a business coalition concerned with health, and two of whom shall be general members. The Speaker of the Assembly shall appoint two members, one of whom shall be a physician and surgeon and one of whom shall be a general member. The Senate Rules Committee shall appoint two members, one of whom shall be a representative of a labor coalition concerned with health, and one of whom shall be a general member.~~

~~The Governor shall designate a member to serve as chairperson for a two-year term. No member may serve more than two, two-year terms as chairperson. All appointments shall be for four-year terms. No individual shall serve more than two, four-year terms.~~

SEC. 22. Section 128700 of the Health and Safety Code is amended to read:

128700. As used in this chapter, the following terms mean:

(a) "Ambulatory surgery procedures" mean those procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic.

~~(b) "Commission" means the California Health Policy and Data Advisory Commission.~~

~~(c)~~

(b) "Emergency department" means, in a hospital licensed to provide emergency medical services, the location in which those services are provided.

~~(d)~~

(c) "Encounter" means a face-to-face contact between a patient and the provider who has primary responsibility for assessing and

treating the condition of the patient at a given contact and exercises independent judgment in the care of the patient.

~~(e)~~

(d) "Freestanding ambulatory surgery clinic" means a surgical clinic that is licensed by the state under paragraph (1) of subdivision (b) of Section 1204.

~~(f)~~

(e) "Health facility" or "health facilities" means all health facilities required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

~~(g)~~

(f) "Hospital" means all health facilities except skilled nursing, intermediate care, and congregate living health facilities.

~~(h)~~

(g) "Office" means the Office of Statewide Health Planning and Development.

~~(i)~~

(h) "Risk-adjusted outcomes" means the clinical outcomes of patients grouped by diagnoses or procedures that have been adjusted for demographic and clinical factors.

SEC. 23. Section 128705 of the Health and Safety Code is amended to read:

128705. On and after January 1, 1986, any reference in this code to the Advisory Health Council ~~shall be deemed a reference to~~ *or* the California Health Policy and Data Advisory Commission *shall be deemed a reference to the office*.

SEC. 24. Section 128710 of the Health and Safety Code is repealed.

~~128710. The California Health Policy and Data Advisory Commission shall meet at least once every two months, or more often if necessary to fulfill its duties.~~

SEC. 25. Section 128715 of the Health and Safety Code is repealed.

~~128715. The members of the commission shall receive per diem of one hundred dollars ($100) for each day actually spent in the discharge of official duties and shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the commission.~~

SEC. 26. Section 128720 of the Health and Safety Code is repealed.

~~128720. The commission may appoint an executive secretary subject to approval by the Secretary of Health and Welfare. The office shall provide other staff to the commission as the office and the commission deem necessary.~~

SEC. 27. Section 128725 of the Health and Safety Code is repealed.

~~128725. The functions and duties of the commission shall include the following:~~

~~(a) Advise the office on the implementation of the new, consolidated data system.~~

~~(b) Advise the office regarding the ongoing need to collect and report health facility data and other provider data.~~

~~(c) Annually develop a report to the director of the office regarding changes that should be made to existing data collection systems and forms. Copies of the report shall be provided to the Senate Health and Human Services Committee and to the Assembly Health Committee.~~

~~(d) Advise the office regarding changes to the uniform accounting and reporting systems for health facilities.~~

~~(e) Conduct public meetings for the purposes of obtaining input from health facilities, other providers, data users, and the general public regarding this chapter and Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.~~

~~(f) Advise the Secretary of Health and Welfare on the formulation of general policies which shall advance the purposes of this part.~~

~~(g) Advise the office on the adoption, amendment, or repeal of regulations it proposes prior to their submittal to the Office of Administrative Law.~~

~~(h) Advise the office on the format of individual health facility or other provider data reports and on any technical and procedural issues necessary to implement this part.~~

~~(i) Advise the office on the formulation of general policies which shall advance the purposes of Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.~~

~~(j) Recommend, in consultation with a 12-member technical advisory committee appointed by the chairperson of the commission, to the office the data elements necessary for the production of outcome reports required by Section 128745.~~

~~(k) (1) The technical advisory committee appointed pursuant to subdivision (j) shall be composed of two members who shall be hospital representatives appointed from a list of at least six persons nominated by the California Association of Hospitals and Health Systems, two members who shall be physicians and surgeons appointed from a list of at least six persons nominated by the California Medical Association, two members who shall be registered nurses appointed from a list of at least six persons nominated by the California Nurses Association, one medical record practitioner who shall be appointed from a list of at least six persons nominated by the California Health Information Association, one member who shall be a representative of a hospital authorized to report as a group pursuant to subdivision (d) of Section 128760, two members who shall be representative of California research organizations experienced in effectiveness review of medical procedures or surgical procedures, or both procedures, one member representing the Health Access Foundation, and one member representing the Consumers Union. Members of the technical advisory committee shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the technical advisory committee.~~

~~(2) The commission shall submit its recommendation to the office regarding the first of the reports required pursuant to subdivision (a) of Section 128745 no later than January 1, 1993. The technical advisory committee shall submit its initial recommendations to the commission pursuant to subdivision (d) of Section 128750 no later than January 1, 1994. The commission, with the advice of the technical advisory committee, may periodically make additional recommendations under Sections 128745 and 128750 to the office, as appropriate.~~

~~(*l*) (1) Assess the value and usefulness of the reports required by Sections 127285, 128735, and 128740. On or before December 1, 1997, the commission shall submit recommendations to the office to accomplish all of the following:~~

~~(A) Eliminate redundant reporting.~~

~~(B) Eliminate collection of unnecessary data.~~

~~(C) Augment data bases as deemed valuable to enhance the quality and usefulness of data.~~

~~(D) Standardize data elements and definitions with other health data collection programs at both the state and national levels.~~

~~(E) Enable linkage with, and utilization of, existing data sets.~~

~~(F) Improve the methodology and data bases used for quality assessment analyses, including, but not limited to, risk-adjusted outcome reports.~~

~~(G) Improve the timeliness of reporting and public disclosure.~~

~~(2) The commission shall establish a committee to implement the evaluation process. The committee shall include representatives from the health care industry, providers, consumers, payers, purchasers, and government entities, including the Department of Managed Health Care, the departments that comprise the Health and Welfare Agency, and others deemed by the commission to be appropriate to the evaluation of the data bases. The committee may establish subcommittees including technical experts.~~

~~(3) In order to ensure the timely implementation of the provisions of the legislation enacted in the 1997–98 Regular Session that amended this part, the office shall present an implementation work plan to the commission. The work plan shall clearly define goals and significant steps within specified timeframes that must be completed in order to accomplish the purposes of that legislation. The office shall make periodic progress reports based on the work plan to the commission. The commission may advise the Secretary of Health and Welfare of any significant delays in following the work plan. If the commission determines that the office is not making significant progress toward achieving the goals outlined in the work plan, the commission shall notify the office and the secretary of that determination. The commission may request the office to submit a plan of correction outlining specific remedial actions and timeframes for compliance. Within 90 days of notification, the office shall submit a plan of correction to the commission.~~

~~(m) (1) As the office and the commission deem necessary, the commission may establish committees and appoint persons who are not members of the commission to these committees as are necessary to carry out the purposes of the commission. Representatives of area health planning agencies shall be invited, as appropriate, to serve on committees established by the office and the commission relative to the duties and responsibilities of area health planning agencies. Members of the standing committees~~

~~shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of these committees.~~

~~(2) Whenever the office or the commission does not accept the advice of the other body on proposed regulations or on major policy issues, the office or the commission shall provide a written response on its action to the other body within 30 days, if so requested.~~

~~(3) The commission or the office director may appeal to the Secretary of Health and Welfare over disagreements on policy, procedural, or technical issues.~~

SEC. 28. Section 128738 of the Health and Safety Code is amended to read:

128738. (a) The office~~, based upon review and recommendations of the commission and its appropriate committees,~~ shall allow and provide for, in accordance with appropriate regulations, additions or deletions to the patient level data elements listed in subdivision (g) of Section 128735, Section 128736, and Section 128737, to meet the purposes of this chapter.

(b) Prior to any additions or deletions, all of the following shall be considered:

(1) Utilization of sampling to the maximum extent possible.

(2) Feasibility of collecting data elements.

(3) Costs and benefits of collection and submission of data.

(4) Exchange of data elements as opposed to addition of data elements.

(c) The office shall add no more than a net of 15 elements to each data set over any five-year period. Elements contained in the uniform claims transaction set or uniform billing form required by the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg) shall be exempt from the 15-element limit.

(d) The~~ commission and the~~ office, in order to minimize costs and administrative burdens, shall consider the total number of data elements required from hospitals and freestanding ambulatory surgery clinics, and optimize the use of common data elements.

SEC. 29. Section 128740 of the Health and Safety Code is amended to read:

128740. (a) Commencing with the first calendar quarter of 1992, the following summary financial and utilization data shall be reported to the office by each hospital within 45 days of the

end of every calendar quarter. Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal or calendar year. The quarterly summary financial and utilization data shall conform to the uniform description of accounts as contained in the Accounting and Reporting Manual for California Hospitals and shall include all of the following:

(1) Number of licensed beds.

(2) Average number of available beds.

(3) Average number of staffed beds.

(4) Number of discharges.

(5) Number of inpatient days.

(6) Number of outpatient visits.

(7) Total operating expenses.

(8) Total inpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(9) Total outpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(10) Deductions from revenue in total and by component, including the following: Medicare contractual adjustments, Medi-Cal contractual adjustments, and county indigent program contractual adjustments, other contractual adjustments, bad debts, charity care, restricted donations and subsidies for indigents, support for clinical teaching, teaching allowances, and other deductions.

(11) Total capital expenditures.

(12) Total net fixed assets.

(13) Total number of inpatient days, outpatient visits, and discharges by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, self-pay, charity, and other payers.

(14) Total net patient revenues by payer including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(15) Other operating revenue.

(16) Nonoperating revenue net of nonoperating expenses.

(b) Hospitals reporting pursuant to subdivision (d) of Section 128760 may provide the items in paragraphs (7), (8), (9), (10),

(14), (15), and (16) of subdivision (a) on a group basis, as described in subdivision (d) of Section 128760.

(c) The office shall make available at cost, to any person, a hard copy of any hospital report made pursuant to this section and in addition to hard copies, shall make available at cost, a computer tape of all reports made pursuant to this section within 105 days of the end of every calendar quarter.

(d) The office~~, with the advice of the commission,~~ shall adopt by regulation guidelines for the identification, assessment, and reporting of charity care services. In establishing the guidelines, the office shall consider the principles and practices recommended by professional health care industry accounting associations for differentiating between charity services and bad debts. The office shall further conduct the onsite validations of health facility accounting and reporting procedures and records as are necessary to assure that reported data are consistent with regulatory guidelines.

This section shall become operative January 1, 1992.

SEC. 30. Section 128745 of the Health and Safety Code is amended to read:

128745. (a) Commencing July 1993, and annually thereafter, the office shall publish risk-adjusted outcome reports in accordance with the following schedule:

Publication Date	Period Covered	Procedures and Conditions Covered
July 1993	1988–90	3
July 1994	1989–91	6
July 1995	1990–92	9

Reports for subsequent years shall include conditions and procedures and cover periods as appropriate.

(b) The procedures and conditions required to be reported under this chapter shall be divided among medical, surgical, and obstetric conditions or procedures and shall be selected by the office~~, based on the recommendations of the commission and the advice of the technical advisory committee set forth in subdivision (j) of Section 128725~~. The office shall publish the risk-adjusted outcome reports for surgical procedures by individual hospital and individual

surgeon unless the office in consultation with ~~the technical advisory committee and~~ medical specialists in the relevant area of practice determines that it is not appropriate to report by individual surgeon. The office, in consultation with the ~~technical advisory committee~~ *clinical panel established by Section 128748* and medical specialists in the relevant area of practice, may decide to report nonsurgical procedures and conditions by individual physician when it is appropriate. The selections shall be in accordance with all of the following criteria:

(1) The patient discharge abstract contains sufficient data to undertake a valid risk adjustment. The risk adjustment report shall ensure that public hospitals and other hospitals serving primarily low-income patients are not unfairly discriminated against.

(2) The relative importance of the procedure and condition in terms of the cost of cases and the number of cases and the seriousness of the health consequences of the procedure or condition.

(3) Ability to measure outcome and the likelihood that care influences outcome.

(4) Reliability of the diagnostic and procedure data.

(c) (1) In addition to any other established and pending reports, on or before July 1, 2002, the office shall publish a risk-adjusted outcome report for coronary artery bypass graft surgery by hospital for all hospitals opting to participate in the report. This report shall be updated on or before July 1, 2003.

(2) In addition to any other established and pending reports, commencing July 1, 2004, and every year thereafter, the office shall publish risk-adjusted outcome reports for coronary artery bypass graft surgery for all coronary artery bypass graft surgeries performed in the state. In each year, the reports shall compare risk-adjusted outcomes by hospital, and in every other year, by hospital and cardiac surgeon. Upon the recommendation of the ~~technical advisory committee~~ *clinical panel established by Section 128748* based on statistical and technical considerations, information on individual hospitals and surgeons may be excluded from the reports.

(3) Unless otherwise recommended by the clinical panel established by Section 128748, the office shall collect the same data used for the most recent risk-adjusted model developed for the California Coronary Artery Bypass Graft Mortality Reporting

Program. Upon recommendation of the clinical panel, the office may add any clinical data elements included in the Society of Thoracic Surgeons' database. Prior to any additions from the Society of Thoracic Surgeons' database, the following factors shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Exchange of data elements as opposed to addition of data elements.

(4) Upon recommendation of the clinical panel, the office may add, delete, or revise clinical data elements, but shall add no more than a net of six elements not included in the Society of Thoracic Surgeons' database, to the data set over any five-year period. Prior to any additions or deletions, all of the following factors shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Feasibility of collecting data elements.

(C) Costs and benefits of collection and submission of data.

(D) Exchange of data elements as opposed to addition of data elements.

(5) The office shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model for the coronary artery bypass graft report.

(6) Patient medical record numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(d) The annual reports shall compare the risk-adjusted outcomes experienced by all patients treated for the selected conditions and procedures in each California hospital during the period covered by each report, to the outcomes expected. Outcomes shall be reported in the five following groupings for each hospital:

(1) "Much higher than average outcomes," for hospitals with risk-adjusted outcomes much higher than the norm.

(2) "Higher than average outcomes," for hospitals with risk-adjusted outcomes higher than the norm.

(3) "Average outcomes," for hospitals with average risk-adjusted outcomes.

(4) "Lower than average outcomes," for hospitals with risk-adjusted outcomes lower than the norm.

(5) "Much lower than average outcomes," for hospitals with risk-adjusted outcomes much lower than the norm.

(e) For coronary artery bypass graft surgery reports and any other outcome reports for which auditing is appropriate, the office shall conduct periodic auditing of data at hospitals.

(f) The office shall publish in the annual reports required under this section the risk-adjusted mortality rate for each hospital and for those reports that include physician reporting, for each physician.

(g) The office shall either include in the annual reports required under this section, or make separately available at cost to any person requesting it, risk-adjusted outcomes data assessing the statistical significance of hospital or physician data at each of the following three levels: 99-percent confidence level (0.01 p-value), 95-percent confidence level (0.05 p-value), and 90-percent confidence level (0.10 p-value). The office shall include any other analysis or comparisons of the data in the annual reports required under this section that the office deems appropriate to further the purposes of this chapter.

SEC. 31. Section 128750 of the Health and Safety Code is amended to read:

128750. (a) Prior to the public release of the annual outcome reports, the office shall furnish a preliminary report to each hospital that is included in the report. The office shall allow the hospital and chief of staff 60 days to review the outcome scores and compare the scores to other California hospitals. A hospital or its chief of staff that believes that the risk-adjusted outcomes do not accurately reflect the quality of care provided by the hospital may submit a statement to the office, within the 60 days, explaining why the outcomes do not accurately reflect the quality of care provided by the hospital. The statement shall be included in an appendix to the public report, and a notation that the hospital or its chief of staff has submitted a statement shall be displayed wherever the report presents outcome scores for the hospital.

(b) (1) Prior to the public release of any outcome report that includes data by a physician, the office shall furnish a preliminary report to each physician that is included in the report. The office shall allow the physician 30 days from the date the office sends

the report to the physician to review the outcome scores and compare the scores to other California physicians. A physician who believes that the risk-adjusted outcome does not accurately reflect the quality of care provided by the physician may submit a statement to the office within the 30 days, explaining why the outcomes do not accurately reflect the quality of care provided by the physician.

(2) The office shall promptly review the physician's statement and shall respond to the physician with one of the following conclusions:

(A) The physician's statement reveals a flaw in the accuracy of the reported data relating to the physician that materially diminishes the validity of the report. If this finding is made, the data for that physician shall not be included in the report until the flaw in the physician's data is corrected.

(B) The physician's statement reveals a flaw in the risk-adjustment model that materially diminishes the value of the report for all physicians. If this finding is made, the report using that risk-adjustment model shall not be issued until the flaw is corrected.

(C) The physician's statement does not reveal a flaw in either the accuracy of the reported data relating to the physician or the risk-adjustment model in which case the report shall be used, unless the physician chooses to use the procedure set forth in paragraph (3).

(3) If a physician is not satisfied with the conclusion reached by the office, the physician shall notify the office of that fact. Upon receipt of the notice, the office shall forward the physician's statement to the appropriate clinical panel appointed pursuant to Section 128748. The office shall forward the physician's statement with any information identifying the physician or the physician's hospital redacted, or shall adopt other means to ensure the physician's identity is not revealed to the panel. The clinical panel shall promptly review the physician statement and the conclusion of the office and shall respond by either upholding the conclusion or reaching one of the other conclusions set forth in this subdivision. The panel decision shall be the final determination regarding the physician's statement. The process set forth in this subdivision shall be completed within 60 days from the date the office sends the report to each physician included in the report. If

a decision by either the office or the clinical panel cannot be reached within the 60-day period, then the outcome report may be issued but shall not include data for the physician submitting the statement.

(c) The office shall, in addition to public reports, provide hospitals and the chiefs of staff of the medical staffs with a report containing additional detailed information derived from data summarized in the public outcome reports as an aid to internal quality assurance.

(d) If, pursuant to the recommendations of the office, ~~based on the advice of the commission, in response to the recommendations of the technical advisory committee made pursuant to subdivision (d) of this section,~~ the Legislature subsequently amends Section 128735 to authorize the collection of additional discharge data elements, then the outcome reports for conditions and procedures for which sufficient data is not available from the current abstract record will be produced following the collection and analysis of the additional data elements.

(e) The recommendations of the ~~technical advisory committee~~ *office* for the addition of data elements to the discharge abstract should take into consideration the technical feasibility of developing reliable risk-adjustment factors for additional procedures and conditions as determined by the ~~technical advisory committee~~ *office* with the advice of the research community, physicians and surgeons, hospitals, consumer or patient advocacy groups, and medical records personnel.

(f) The ~~technical advisory committee~~ *office* at a minimum shall identify a limited set of core clinical data elements to be collected for all of the added procedures and conditions and unique clinical variables necessary for risk adjustment of specific conditions and procedures selected for the outcomes report program. In addition, the committee should give careful consideration to the costs associated with the additional data collection and the value of the specific information to be collected.

(g) The ~~technical advisory committee~~ *office* shall also engage in a continuing process of data development and refinement applicable to both current and prospective outcome studies.

SEC. 32. Section 128760 of the Health and Safety Code is amended to read:

128760. (a) On and after January 1, 1986, those systems of health facility accounting and auditing formerly approved by the California Health Facilities Commission shall remain in full force and effect for use by health facilities but shall be maintained by the office ~~with the advice of the Health Policy and Data Advisory Commission~~.

(b) The office~~, with the advice of the commission,~~ shall allow and provide, in accordance with appropriate regulations, for modifications in the accounting and reporting systems for use by health facilities in meeting the requirements of this chapter if the modifications are necessary to do any of the following:

(1) To correctly reflect differences in size of, provision of, or payment for, services rendered by health facilities.

(2) To correctly reflect differences in scope, type, or method of provision of, or payment for, services rendered by health facilities.

(3) To avoid unduly burdensome costs for those health facilities in meeting the requirements of differences pursuant to paragraphs (1) and (2).

(c) Modifications to discharge data reporting requirements. The office~~, with the advice of the commission,~~ shall allow and provide, in accordance with appropriate regulations, for modifications to discharge data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not be construed to permit the office to administratively require the reporting of discharge data items not specified pursuant to Section 128735.

(d) Modifications to emergency care data reporting requirements. The office~~, with the advice of the commission,~~ shall allow and provide, in accordance with appropriate regulations, for modifications to emergency care data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not be construed to permit the office to require administratively the reporting of emergency care data items not specified in subdivision (a) of Section 128736.

(e) Modifications to ambulatory surgery data reporting requirements. The office~~, with the advice of the commission,~~ shall allow and provide, in accordance with appropriate regulations, for

modifications to ambulatory surgery data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. The modification authority shall not be construed to permit the office to require administratively the reporting of ambulatory surgery data items not specified in subdivision (a) of Section 128737.

(f) Reporting provisions for health facilities. The office~~, with the advice of the commission,~~ shall establish specific reporting provisions for health facilities that receive a preponderance of their revenue from associated comprehensive group-practice prepayment health care service plans. These health facilities shall be authorized to utilize established accounting systems, and to report costs and revenues in a manner that is consistent with the operating principles of these plans and with generally accepted accounting principles. When these health facilities are operated as units of a coordinated group of health facilities under common management, they shall be authorized to report as a group rather than as individual institutions. As a group, they shall submit a consolidated income and expense statement.

(g) Hospitals authorized to report as a group under this subdivision may elect to file cost data reports required under the regulations of the Social Security Administration in its administration of Title XVIII of the federal Social Security Act in lieu of any comparable cost reports required under Section 128735. However, to the extent that cost data is required from other hospitals, the cost data shall be reported for each individual institution.

(h) The office~~, with the advice of the commission,~~ shall adopt comparable modifications to the financial reporting requirements of this chapter for county hospital systems consistent with the purposes of this chapter.

SEC. 33. Section 128765 of the Health and Safety Code is amended to read:

128765. (a) The office~~, with the advice of the commission,~~ shall maintain a file of all the reports filed under this chapter at its Sacramento office. Subject to any rules the office~~, with the advice of the commission,~~ may prescribe, these reports shall be produced and made available for inspection upon the demand of any person, and shall also be posted on its Web site, with the exception of

discharge and encounter data that shall be available for public inspection unless the office determines, pursuant to applicable law, that an individual patient's rights of confidentiality would be violated.

(b) The reports published pursuant to Section 128745 shall include an executive summary, written in plain English to the maximum extent practicable, that shall include, but not be limited to, a discussion of findings, conclusions, and trends concerning the overall quality of medical outcomes, including a comparison to reports from prior years, for the procedure or condition studied by the report. The office shall disseminate the reports as widely as practical to interested parties, including, but not limited to, hospitals, providers, the media, purchasers of health care, consumer or patient advocacy groups, and individual consumers. The reports shall be posted on the office's Internet Web site.

(c) Copies certified by the office as being true and correct copies of reports properly filed with the office pursuant to this chapter, together with summaries, compilations, or supplementary reports prepared by the office, shall be introduced as evidence, where relevant, at any hearing, investigation, or other proceeding held, made, or taken by any state, county, or local governmental agency, board, or commission that participates as a purchaser of health facility services pursuant to the provisions of a publicly financed state or federal health care program. Each of these state, county, or local governmental agencies, boards, and commissions shall weigh and consider the reports made available to it pursuant to the provisions of this subdivision in its formulation and implementation of policies, regulations, or procedures regarding reimbursement methods and rates in the administration of these publicly financed programs.

(d) The office~~, with the advice of the commission,~~ shall compile and publish summaries of individual facility and aggregate data that do not contain patient-specific information for the purpose of public disclosure. The summaries shall be posted on the office's Internet Web site. The~~ commission shall approve the policies and procedures relative to the manner of data disclosure to the public. The office, with the advice of the commission,~~ *office* may initiate and conduct studies as it determines will advance the purposes of this chapter.

(e) In order to assure that accurate and timely data are available to the public in useful formats, the office shall establish a public liaison function. The public liaison shall provide technical assistance to the general public on the uses and applications of individual and aggregate health facility data and shall provide the director ~~and the commission~~ with an annual report on changes that can be made to improve the public's access to data.

SEC. 34. Section 128770 of the Health and Safety Code is amended to read:

128770. (a) Any health facility or freestanding ambulatory surgery clinic that does not file any report as required by this chapter with the office is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of any report is delayed. No penalty shall be imposed if an extension is granted in accordance with the guidelines and procedures established by the office~~, with the advice of the commission~~.

(b) Any health facility that does not use an approved system of accounting pursuant to the provisions of this chapter for purposes of submitting financial and statistical reports as required by this chapter shall be liable for a civil penalty of not more than five thousand dollars ($5,000).

(c) Civil penalties are to be assessed and recovered in a civil action brought in the name of the people of the State of California by the office. Assessment of a civil penalty may, at the request of any health facility or freestanding ambulatory surgery clinic, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(d) Any money that is received by the office pursuant to this section shall be paid into the General Fund.

SEC. 35. Section 128775 of the Health and Safety Code is amended to read:

128775. (a) Any health facility or freestanding ambulatory surgery clinic affected by any determination made under this part by the office may petition the office for review of the decision. This petition shall be filed with the office within 15 business days, or within a greater time as the office~~, with the advice of the commission,~~ may allow, and shall specifically describe the matters which are disputed by the petitioner.

(b) A hearing shall be commenced within 60 calendar days of the date on which the petition was filed. The hearing shall be held

before an employee of the office, *or* an administrative law judge employed by the Office of Administrative Hearings~~, or a committee of the commission chosen by the chairperson for this purpose~~. If held before an employee of the office~~ or a committee of the commission~~, the hearing shall be held in accordance with any procedures as the office~~, with the advice of the commission,~~ shall prescribe. If held before an administrative law judge employed by the Office of Administrative Hearings, the hearing shall be held in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The employee~~,~~ *or* administrative law judge~~, or committee~~ shall prepare a recommended decision including findings of fact and conclusions of law and present it to the office for its adoption. The decision of the office shall be in writing and shall be final. The decision of the office shall be made within 60 calendar days after the conclusion of the hearing and shall be effective upon filing and service upon the petitioner.

(c) Judicial review of any final action, determination, or decision may be had by any party to the proceedings as provided in Section 1094.5 of the Code of Civil Procedure. The decision of the office shall be upheld against a claim that its findings are not supported by the evidence unless the court determines that the findings are not supported by substantial evidence.

(d) The employee of the office, *or* the administrative law judge employed by the Office of Administrative Hearings~~,~~ *or* the Office of Administrative Hearings,~~ or the committee of the commission~~ may issue subpoenas and subpoenas duces tecum in a manner and subject to the conditions established by Article 11 (commencing with Section 11450.10) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of the Government Code.

(e) This section shall become operative on July 1, 1997.

SEC. 36. Section 128785 of the Health and Safety Code is amended to read:

128785. On January 1, 1986, all regulations previously adopted by the California Health Facilities Commission that relate to functions vested in the office and that are in effect on that date, shall remain in effect and shall be fully enforceable to the extent that they are consistent with this chapter, as determined by the office, unless and until readopted, amended, or repealed by the office~~ following review and comment by the commission~~.

SEC. 37. Section 128810 of the Health and Safety Code is amended to read:

128810. The office shall administer this chapter and shall make all regulations necessary to implement the provisions and achieve the purposes stated herein. ~~The commission shall advise and consult with the office in carrying out the administration of this chapter.~~

SEC. 38. Section 129010 of the Health and Safety Code is amended to read:

129010. Unless the context otherwise requires, the definitions in this section govern the construction of this chapter and of Section 32127.2.

(a) "Bondholder" means the legal owner of a bond or other evidence of indebtedness issued by a political subdivision or a nonprofit corporation.

(b) "Borrower" means a political subdivision or nonprofit corporation that has secured or intends to secure a loan for the construction of a health facility.

(c) "Construction, improvement, or expansion" or "construction, improvement, and expansion" includes construction of new buildings, expansion, modernization, renovation, remodeling and alteration of existing buildings, acquisition of existing buildings or health facilities, and initial or additional equipping of any of these buildings.

In connection therewith, "construction, improvement, or expansion" or "construction, improvement, and expansion" includes the cost of construction or acquisition of all structures, including parking facilities, real or personal property, rights, rights-of-way, the cost of demolishing or removing any buildings or structures on land so acquired, including the cost of acquiring any land where the buildings or structures may be moved, the cost of all machinery and equipment, financing charges, interest (prior to, during and for a period after completion of the construction), provisions for working capital, reserves for principal and interest and for extensions, enlargements, additions, replacements, renovations and improvements, cost of engineering, financial and legal services, plans, specifications, studies, surveys, estimates of cost and of revenues, administrative expenses, expenses necessary or incident to determining the feasibility or practicability of constructing or incident to the construction; or the financing of the construction or acquisition.

~~(d) "Commission" means the California Health Policy and Data Advisory Commission.~~

~~(e)~~

(d) "Committee" means the Advisory Loan Insurance Committee.

~~(f)~~

(e) "Debenture" means any form of written evidence of indebtedness issued by the State Treasurer pursuant to this chapter, as authorized by Section 4 of Article XVI of the California Constitution.

~~(g)~~

(f) "Fund" means the Health Facility Construction Loan Insurance Fund.

~~(h)~~

(g) "Health facility" means any facility providing or designed to provide services for the acute, convalescent, and chronically ill and impaired, including, but not limited to, public health centers, community mental health centers, facilities for the developmentally disabled, nonprofit community care facilities that provide care, habilitation, rehabilitation or treatment to developmentally disabled persons, facilities for the treatment of chemical dependency, including a community care facility, licensed pursuant to Chapter 3 (commencing with Section 1500) of Division 2, a clinic, as defined pursuant to Chapter 1 (commencing with Section 1200) of Division 2, an alcoholism recovery facility, defined pursuant to former Section 11834.11, and a structure located adjacent or attached to another type of health facility and that is used for storage of materials used in the treatment of chemical dependency, and general tuberculosis, mental, and other types of hospitals and related facilities, such as laboratories, outpatient departments, extended care, nurses' home and training facilities, offices and central service facilities operated in connection with hospitals, diagnostic or treatment centers, extended care facilities, nursing homes, and rehabilitation facilities. "Health facility" also means an adult day health center and a multilevel facility. Except for facilities for the developmentally disabled, facilities for the treatment of chemical dependency, or a multilevel facility, or as otherwise provided in this subdivision, "health facility" does not include any institution furnishing primarily domiciliary care.

"Health facility" also means accredited nonprofit work activity programs as defined in subdivision (e) of Section 19352 and Section 19355 of the Welfare and Institutions Code, and nonprofit community care facilities as defined in Section 1502, excluding foster family homes, foster family agencies, adoption agencies, and residential care facilities for the elderly.

Unless the context dictates otherwise, "health facility" includes a political subdivision of the state or nonprofit corporation that operates a facility included within the definition set forth in this subdivision.

~~(i)~~

(h) "Office" means the Office of Statewide Health Planning and Development.

~~(j)~~

(i) "Lender" means the provider of a loan and its successors and assigns.

~~(k)~~

(j) "Loan" means money or credit advanced for the costs of construction or expansion of the health facility, and includes both initial loans and loans secured upon refinancing and may include both interim, or short-term loans, and long-term loans. A duly authorized bond or bond issue, or an installment sale agreement, may constitute a "loan."

~~(*l*)~~

(k) "Maturity date" means the date that the loan indebtedness would be extinguished if paid in accordance with periodic payments provided for by the terms of the loan.

~~(m)~~

(l) "Mortgage" means a first mortgage on real estate. "Mortgage" includes a first deed of trust.

~~(n)~~

(m) "Mortgagee" includes a lender whose loan is secured by a mortgage. "Mortgagee" includes a beneficiary of a deed of trust.

~~(o)~~

(n) "Mortgagor" includes a borrower, a loan to whom is secured by a mortgage, and the trustor of a deed of trust.

~~(p)~~

(o) "Nonprofit corporation" means any corporation formed under or subject to the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 1

of the Corporations Code) that is organized for the purpose of owning and operating a health facility and that also meets the requirements of Section 501(c)(3) of the Internal Revenue Code.

~~(q)~~

(p) "Political subdivision" means any city, county, joint powers entity, local hospital district, or the California Health Facilities Authority.

~~(r)~~

(q) "Project property" means the real property where the health facility is, or is to be, constructed, improved, or expanded, and also means the health facility and the initial equipment in that health facility.

~~(s)~~

(r) "Public health facility" means any health facility that is or will be constructed for and operated and maintained by any city, county, or local hospital district.

~~(t)~~

(s) "Adult day health center" means a facility defined under subdivision (b) of Section 1570.7, that provides adult day health care, as defined under subdivision (a) of Section 1570.7.

~~(u)~~

(t) "Multilevel facility" means an institutional arrangement where a residential facility for the elderly is operated as a part of, or in conjunction with, an intermediate care facility, a skilled nursing facility, or a general acute care hospital. "Elderly," for the purposes of this subdivision, means a person 60 years of age or older.

~~(v)~~

(u) "State plan" means the plan described in Section 129020.

SEC. 39. Section 129015 of the Health and Safety Code is amended to read:

129015. The office shall administer this chapter and shall make all regulations necessary to implement the provisions and achieve the purposes stated herein. ~~The commission, as authorized by this chapter and by Section 129460, shall advise and consult with the office in carrying out the administration of this chapter.~~

SEC. 40. Section 129100 of the Health and Safety Code is amended to read:

129100. Every applicant for insurance shall be afforded an opportunity for a fair hearing before the ~~commission~~ *committee*

upon 10 days' written notice to the applicant. If the office, after affording reasonable opportunity for development and presentation of the application and after receiving the advice of the ~~commission~~ *committee*, finds that an application complies with the requirements of this article and of Section 129020 and is otherwise in conformity with the state plan, it may approve the application for insurance. The office shall consider and approve applications in the order of relative need set forth in the state plan in accordance with Section 129020. Judicial review of a final decision made under this section may be had by filing a petition for writ of mandate. Any petition shall be filed within 30 days after the date of the final decision of the office.

SEC. 41. Section 10618.6 of the Welfare and Institutions Code is amended to read:

10618.6. *(a)* When a youth in a foster care placement reaches his or her 16th birthday, the county welfare department shall request a consumer disclosure, pursuant to the free annual disclosure provision of the federal Fair Credit Reporting Act, on the youth's behalf, notwithstanding any other ~~provision of~~ law, to ascertain whether or not identity theft has occurred. If there is a disclosure for the youth and if the consumer disclosure reveals any negative items, or any evidence that some form of identity theft has occurred, the county welfare department shall refer the youth to an approved counseling organization that provides services to victims of identity theft. The State Department of Social Services, in consultation with the County Welfare Directors Association, consumer credit reporting agencies, and other relevant stakeholders, shall develop a list of approved organizations to which youth may be referred for assistance in responding to an instance of suspected identity theft. ~~Nothing in this~~ *This* section shall *not* be construed to require the county welfare department to request more than one consumer disclosure on behalf of a youth in care, or to take steps beyond referring the youth to an approved organization.

(b) This section shall not be implemented until July 1, 2013.

SEC. 42. Section 11265.2 of the Welfare and Institutions Code, as amended by Section 5 of Chapter 8 of the Statutes of 2011, is amended to read:

11265.2. (a) The grant amount a recipient shall be entitled to receive for each month of the quarterly reporting period shall be prospectively determined as provided by this section. If a recipient

reports that he or she does not anticipate any changes in income during the upcoming quarter, compared to the income the recipient reported actually receiving on the quarterly report form, the grant shall be calculated using the actual income received. If a recipient reports that he or she anticipates a change in income in one or more months of the upcoming quarter, the county shall determine whether the recipient's income is reasonably anticipated. The grant shall be calculated using the income that the county determines is reasonably anticipated in each of the three months of the upcoming quarter.

(b) For the purposes of the quarterly reporting, prospective budgeting system, income shall be considered to be "reasonably anticipated" if the county is reasonably certain of the amount of income and that the income will be received during the quarterly reporting period. The county shall determine what income is "reasonably anticipated" based on information provided by the recipient and any other available information.

(c) If a recipient reports that their income in the upcoming quarter will be different each month and the county needs additional information to determine a recipient's reasonably anticipated income for the following quarter, the county may require the recipient to provide information about income for each month of the prior quarter.

(d) Grant calculations pursuant to subdivision (a) may not be revised to adjust the grant amount during the quarterly reporting period, except as provided in Section 11265.3 and subdivisions (e), (f), (g), and (h), and as otherwise established by the department.

(e) Notwithstanding subdivision (d), statutes and regulations relating to (1) the 48-month ~~or 60-month~~ time limit, (2) age limitations for children under Section 11253, and (3) sanctions and financial penalties affecting eligibility or grant amount shall be applicable as provided in those statutes and regulations. Eligibility and grant amount shall be adjusted during the quarterly reporting period pursuant to those statutes and regulations effective with the first monthly grant after timely and adequate notice is provided.

(f) Notwithstanding Section 11056, if an applicant applies for assistance for a child who is currently aided in another assistance unit, and the county determines that the applicant has care and control of the child, as specified by the department, and is

otherwise eligible, the county shall discontinue aid to the child in the existing assistance unit and shall aid the child in the applicant's assistance unit effective as of the first of the month following the discontinuance of the child from the existing assistance unit.

(g) If the county is notified that a child for whom CalWORKs assistance is currently being paid has been placed in a foster care home, the county shall discontinue aid to the child at the end of the month of placement. The county shall discontinue the case if the remaining assistance unit members are not otherwise eligible.

(h) If the county determines that a recipient is no longer a California resident, pursuant to Section 11100, the recipient shall be discontinued. The county shall discontinue the case if the remaining assistance unit members are not otherwise eligible.

SEC. 43. Section 11320.15 of the Welfare and Institutions Code, as amended by Section 7 of Chapter 8 of the Statutes of 2011, is amended to read:

11320.15. After a participant has been removed from the assistance unit under subdivision (a) of Section 11454, additional welfare-to-work services may be provided to the recipient, at the option of the county. If the county provides services to the recipient after the 48-month ~~or 60-month~~ limit has been reached, the recipient shall participate in community service *or subsidized employment, as described in Section 11322.63*.

SEC. 44. Section 11320.3 of the Welfare and Institutions Code, as amended by Section 9 of Chapter 8 of the Statutes of 2011, is amended to read:

11320.3. (a) (1) Except as provided in subdivision (b) or if otherwise exempt, every individual, as a condition of eligibility for aid under this chapter, shall participate in welfare-to-work activities under this article.

(2) Individuals eligible under Section 11331.5 shall be required to participate in the Cal-Learn Program under Article 3.5 (commencing with Section 11331) during the time that article is operative, in lieu of the welfare-to-work requirements, and subdivision (b) shall not apply to that individual.

(b) The following individuals shall not be required to participate for so long as the condition continues to exist:

(1) An individual under 16 years of age.

(2) (A) A child attending an elementary, secondary, vocational, or technical school on a full-time basis.

(B) A person who is 16 or 17 years of age, or a person described in subdivision (d) who loses this exemption, shall not requalify for the exemption by attending school as a required activity under this article.

(C) Notwithstanding subparagraph (B), a person who is 16 or 17 years of age who has obtained a high school diploma or its equivalent and is enrolled or is planning to enroll in a postsecondary education, vocational, or technical school training program shall also not be required to participate for so long as the condition continues to exist.

(D) For purposes of subparagraph (C), a person shall be deemed to be planning to enroll in a postsecondary education, vocational, or technical school training program if he or she, or his or her parent, acting on his or her behalf, submits a written statement expressing his or her intent to enroll in such a program for the following term. The exemption from participation shall not continue beyond the beginning of the term, unless verification of enrollment is provided or obtained by the county.

(3) An individual who meets either of the following conditions:

(A) The individual is disabled as determined by a doctor's verification that the disability is expected to last at least 30 days and that it significantly impairs the recipient's ability to be regularly employed or participate in welfare-to-work activities, provided that the individual is actively seeking appropriate medical treatment.

(B) The individual is of advanced age.

(4) A nonparent caretaker relative who has primary responsibility for providing care for a child and is either caring for a child who is a dependent or ward of the court or caring for a child in a case in which a county determines the child is at risk of placement in foster care, and the county determines that the caretaking responsibilities are beyond those considered normal day-to-day parenting responsibilities such that they impair the caretaker relative's ability to be regularly employed or to participate in welfare-to-work activities.

(5) An individual whose presence in the home is required because of illness or incapacity of another member of the household and whose caretaking responsibilities impair the recipient's ability to be regularly employed or to participate in welfare-to-work activities.

(6) A parent or other relative who meets the criteria in subparagraph (A) or (B).

(A) (i) The parent or other relative has primary responsibility for personally providing care to a child six months of age or under, except that, on a case-by-case basis, and based on criteria developed by the county, this period may be reduced to the first 12 weeks after the birth or adoption of the child, or increased to the first 12 months after the birth or adoption of the child. An individual may be exempt only once under this clause.

(ii) An individual who received an exemption pursuant to clause (i) shall be exempt for a period of 12 weeks, upon the birth or adoption of any subsequent children, except that this period may be extended on a case-by-case basis to six months, based on criteria developed by the county.

(iii) In making the determination to extend the period of exception under clause (i) or (ii), the following may be considered:

(I) The availability of child care.

(II) Local labor market conditions.

(III) Other factors determined by the county.

(B) In a family eligible for aid under this chapter due to the unemployment of the principal wage earner, the exemption criteria contained in subparagraph (A) shall be applied to only one parent.

(7) ~~(A)~~ A parent or other relative who has primary responsibility for personally providing care to one child who is from 12 to 23 months of age, inclusive, or two or more children who are under six years of age.

~~(B) The exemption provided for in subparagraph (A) shall be extended to include a parent or other relative who has primary responsibility for personally providing care to one child who is from 24 to 35 months of age, inclusive, if the parent or caretaker relative resides in a county that has made a finding that it is necessary to extend the exemption in this manner in order to implement its portion of the reduction to the CalWORKs program single allocation, in accordance with Item No. 5180-101-0001 of Section 2 of the Budget Act of 2011. The county may rescind a finding made pursuant to this subparagraph if it determines the extended age exemption is no longer necessary.~~

(8) A woman who is pregnant and for whom it has been medically verified that the pregnancy impairs her ability to be regularly employed or participate in welfare-to-work activities or

the county has determined that, at that time, participation will not readily lead to employment or that a training activity is not appropriate.

(c) Any individual not required to participate may choose to participate voluntarily under this article, and end that participation at any time without loss of eligibility for aid under this chapter, if his or her status has not changed in a way that would require participation.

(d) (1) Notwithstanding subdivision (a), a custodial parent who is under 20 years of age and who has not earned a high school diploma or its equivalent, and who is not exempt or whose only basis for exemption is paragraph (1), *(2)*, (5), (6), (7), or (8) of subdivision (b), shall be required to participate solely for the purpose of earning a high school diploma or its equivalent. During the time that Article 3.5 (commencing with Section 11331) is operative, this subdivision shall only apply to a custodial parent who is 19 years of age.

(2) Section 11325.25 shall apply to a custodial parent who is 18 or 19 years of age and who is required to participate under this article.

(e) Notwithstanding paragraph (1) of subdivision (d), the county may determine that participation in education activities for the purpose of earning a high school diploma or equivalent is inappropriate for an 18 or 19 year old custodial parent only if that parent is reassigned pursuant to an evaluation under Section 11325.25, or, at appraisal is already in an educational or vocational training program that is approvable as a self-initiated program as specified in Section 11325.23. If that determination is made, the parent shall be allowed to continue participation in the self-initiated program subject to Section 11325.23. During the time that Article 3.5 (commencing with Section 11331) is operative, this subdivision shall only apply to a custodial parent who is 19 years of age.

(f) A recipient shall be excused from participation for good cause when the county has determined there is a condition or other circumstance that temporarily prevents or significantly impairs the recipient's ability to be regularly employed or to participate in welfare-to-work activities. The county welfare department shall review the good cause determination for its continuing appropriateness in accordance with the projected length of the condition, or circumstance, but not less than every three months.

The recipient shall cooperate with the county welfare department and provide information, including written documentation, as required to complete the review. Conditions that may be considered good cause include, but are not limited to, the following:

(1) Lack of necessary supportive services.

(2) In accordance with Article 7.5 (commencing with Section 11495), the applicant or recipient is a victim of domestic violence, but only if participation under this article is detrimental to or unfairly penalizes that individual or his or her family.

(3) Licensed or license-exempt child care for a child 10 years of age or younger is not reasonably available during the individual's hours of training or employment including commuting time, or arrangements for child care have broken down or have been interrupted, or child care is needed for a child who meets the criteria of subparagraph (C) of paragraph (1) of subdivision (a) of Section 11323.2, but who is not included in the assistance unit. For purposes of this paragraph, "reasonable availability" means child care that is commonly available in the recipient's community to a person who is not receiving aid and that is in conformity with the requirements of Public Law 104-193. The choices of child care shall meet either licensing requirements or the requirements of Section 11324. This good cause criterion shall include the unavailability of suitable special needs child care for children with identified special needs, including, but not limited to, disabilities or chronic illnesses.

(g) (1) Paragraph (7) of subdivision (b) shall be implemented notwithstanding Sections 11322.4, 11322.7, 11325.6, and 11327, and shall become inoperative on July 1, 2012.

(2) The State Department of Social Services, in consultation with the County Welfare Directors Association of California, shall develop a process prior to January 1, 2012, to assist clients with reengagement in welfare-to-work activities by July 1, 2012. Reengagement activities may include notifying clients of the expiration of exemptions, potential reassessments, and identifying necessary supportive services.

SEC. 45. Section 11322.63 of the Welfare and Institutions Code is amended to read:

11322.63. (a) For counties that implement a welfare-to-work plan that includes activities pursuant to subdivisions (b) and (c) of Section 11322.6, the State Department of Social Services shall

pay the county 50 percent, less fifty-six dollars ($56), of the total wage costs of an employee for whom a wage subsidy is paid, subject to all of the following conditions:

(1) (A) For participants receiving CalWORKs aid, the maximum state contribution of the total wage cost shall not exceed 100 percent of the computed grant for the assistance unit in the month prior to participation in subsidized employment.

(B) For participants who have received aid in excess of the time limits provided in subdivision (a) of Section 11454, the maximum state contribution of the total wage cost, shall not exceed 100 percent of the computed grant for the assistance unit in the month prior to participation in subsidized employment~~, with any reduction required by Section 11450.025~~.

(C) In the case of an individual who participates in subsidized employment as a service provided by a county pursuant to Section 11323.25, the maximum state contribution of the total wage cost shall not exceed 100 percent of the computed grant that the assistance unit received in the month prior to participation in the subsidized employment.~~ For participants who have received aid in excess of the time limits provided in subdivision (a) of Section 11454, the maximum state contribution under this subparagraph shall also be reduced as described in Section 11450.025.~~

(D) The maximum state contribution, as defined in this paragraph, shall remain in effect until the end of the subsidy period as specified in paragraph (2), including with respect to subsidized employment participants whose wage results in the assistance unit no longer receiving a CalWORKs grant.

(E) State funding provided for total wage costs shall only be used to fund wage and nonwage costs of the county's subsidized employment program.

(2) State participation in the total wage costs pursuant to this section shall be limited to a maximum of six months of wage subsidies for each participant. If the county finds that a longer subsidy period is necessary in order to mutually benefit the employer and the participant, state participation in a subsidized wage may be offered for up to 12 months.

(3) Eligibility for entry into subsidized employment funded under this section shall be limited to individuals who are not otherwise employed at the time of entry into the subsidized job, and who are current CalWORKs recipients, sanctioned individuals,

or individuals described in Section 11320.15 who have exceeded the time limits specified in subdivision (a) of Section 11454. A county may continue to provide subsidized employment funded under this section to individuals who become ineligible for CalWORKs benefits in accordance with Section 11323.25.

(b) Upon application for CalWORKs after a participant's subsidized employment ends, if an assistance unit is otherwise eligible within three calendar months of the date that subsidized employment ended, the income exemption requirements contained in Section 11451.5 and the work requirements contained in subdivision (c) of Section 11201 shall apply. If aid is restored after the expiration of that three-month period, the income exemption requirements contained in Section 11450.12 and the work requirements contained in subdivision (b) of Section 11201 shall apply.

(c) The department, in conjunction with representatives of county welfare offices and their directors and the Legislative Analyst's Office, shall assess the cost neutrality of the subsidized employment program pursuant to this section and make recommendations to the Legislature, if necessary, to ensure cost neutrality. The department shall testify regarding the cost neutrality of the subsidized employment program during the 2012–13 fiscal year legislative budget hearings.

(d) No later than January 10, 2013, the State Department of Social Services shall submit a report to the Legislature on the outcomes of implementing this section that shall include, but need not be limited to, all of the following:

(1) The number of CalWORKs recipients that entered subsidized employment.

(2) The number of CalWORKs recipients who found nonsubsidized employment after the subsidy ends.

(3) The earnings of the program participants before and after the subsidy.

(4) The impact of this program on the state's work participation rate.

(e) Payment of the state's share in total wage costs required by this section shall be made in addition to, and independent of, the county allocations made pursuant to Section 15204.2.

(f) For purposes of this section, "total wage costs" include the actual wage paid directly to the participant that is allowable under the Temporary Assistance for Needy Families program.

SEC. 45.5. Section 11329.5 of the Welfare and Institutions Code is amended to read:

11329.5. With respect to paragraph (7) of subdivision (b) of Section 11320.3 and Section 11325.71, the Legislature finds and declares all of the following, but only for the operative period of these added provisions:

(a) Due to the significant General Fund revenue decline for the 2009–10 fiscal year, funding has been reduced for the CalWORKs program.

(b) Due to the federal funding available under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) (ARRA) for CalWORKs grants, reductions in 2009–10 are being achieved in the county single allocation.

(c) Reduced funding, including a three-hundred-seventy-five-million-dollar ($375,000,000) reduction to the county single allocation in the 2009–10 and 2010–11 Budget Acts, and increased caseload for CalWORKs will result in insufficient resources to provide the full range of welfare-to-work services in the 2009–10 and 2010–11 fiscal years.

(d) Reduced funding, including a ~~four-hundred-twenty-seven-million-dollar ($427,000,000)~~ *three hundred seventy–six million eight hundred fifty thousand dollar ($376,850,000)* reduction to the county single allocation in the 2011–12 Budget Act, will result in insufficient resources to provide the full range of welfare-to-work services in the 2011–12 fiscal year.

(e) It is the intent of the Legislature that the limited resources for CalWORKs services be effectively utilized, as established in paragraph (7) of subdivision (b) of Section 11320.3.

(f) It is the further intent of the Legislature to provide additional flexibility to address funding constraints, as established in Section 11325.71, in addition to the existing flexibility provided under subdivision (f) of Section 11320.3.

(g) It is the further intent of the Legislature to minimize disruption of welfare-to-work services for individuals already participating, and prioritize exemptions and good cause for applicants.

(h) Funding and caseload factors will result in circumstances beyond the control of the counties in the 2009–10, 2010–11, and 2011–12 fiscal years, and relief should be provided for federal penalties that may result.

SEC. 46. Section 11334.8 of the Welfare and Institutions Code is amended to read:

11334.8. (a) Except as provided in subdivision (b), this article shall be inoperative from July 1, 2011, to June 30, 2012, inclusive.

(b) Notwithstanding subdivision (a), bonuses and supplements shall continue to be paid to eligible participants pursuant to subdivisions (a), (c), and (e) of Section 11333.7, and related requirements pursuant to Sections 11334.2 and 11334.5 shall also be operative, during the period that the remainder of this article is inoperative pursuant to subdivision (a).

(c) Notwithstanding subdivision (b) of Section 11450, a pregnant woman with no other children who was determined to be eligible for aid in the first or second trimester of her pregnancy for purposes of participating in the Cal-Learn Program prior to July 1, 2011, shall continue to receive aid during the suspension of the Cal-Learn Program described in this section, as long as she remains otherwise eligible for aid under this chapter.

~~(c)~~

(d) This section shall remain in effect only until July 1, 2012, and as of that date is repealed, unless a later enacted statute, that is enacted before July 1, 2012, deletes or extends that date.

SEC. 47. Section 11364 of the Welfare and Institutions Code, as added by Section 34 of Chapter 559 of the Statutes of 2010, is amended to read:

11364. (a) In order to receive payments under this article, the county child welfare agency, probation department, or Indian tribe that has entered into an agreement pursuant to Section 10553.1, shall negotiate and enter into a written, binding, kinship guardianship assistance agreement with the relative guardian of an eligible child, and provide the relative guardian with a copy of the agreement.

(b) The agreement shall specify, at a minimum, all of the following:

(1) The amount of and manner in which the kinship guardianship assistance payment will be provided under the agreement, *and that the amount is subject to any applicable increases pursuant to*

cost-of-living adjustments established by statute, and the manner in which the agreement may be adjusted periodically, but no less frequently than every two years, in consultation with the relative guardian, based on the circumstances of the relative guardian and the needs of the child.

(2) Additional services and assistance for which the child and relative guardian will be eligible under the agreement.

(3) A procedure by which the relative guardian may apply for additional services, as needed, including the filing of a petition under Section 388 to have dependency jurisdiction resumed pursuant to subdivision (b) of Section 366.3.

(4) That the agreement shall remain in effect regardless of the state of residency of the relative guardian.

(5) The responsibility of the relative guardian for reporting changes in the needs of the child or the circumstances of the relative guardian that affect payment.

(c) In accordance with the Kin-GAP agreement, the relative guardian shall be paid an amount of aid based on the child's needs otherwise covered in AFDC-FC payments and the circumstances of the relative guardian, but that shall not exceed the foster care maintenance payment that would have been paid based on the age-related state-approved foster family home care rate and any applicable specialized care increment for a child placed in a licensed or approved family home pursuant to subdivisions (a) to (d), inclusive, of Section 11461. In addition, the rate paid for a child eligible for a Kin-GAP payment shall include an amount equal to the clothing allowance, as set forth in subdivision (f) of Section 11461, including any applicable rate adjustments. For a child eligible for a Kin-GAP payment who is a teen parent, the rate shall include the two hundred dollar ($200) monthly payment made to the relative caregiver in a whole family foster home pursuant to paragraph (3) of subdivision (d) of Section 11465.

(d) Commencing on the effective date of the act that added this subdivision, and notwithstanding subdivision (c), in accordance with the Kin-GAP agreement, the relative guardian shall be paid an amount of aid based on the child's needs otherwise covered in AFDC-FC payments and the circumstances of the relative guardian, as follows:

(1) For cases in which the dependency has been dismissed pursuant to Section 366.3 or wardship has been terminated

pursuant to subdivision (e) of Section 728, concurrently or subsequently to establishment of the guardianship, on or before June 30, 2011, or the date specified in a final order, for which the time to appeal has passed, issued by a court of competent jurisdiction in California State Foster Parent Association, et al. v. William Lightbourne, et al. (U.S. Dist. Ct. No. C 07-05086 WHA), whichever is earlier, the rate paid shall not exceed the basic foster care maintenance payment rate structure in effect prior to the effective date specified in the order described in this paragraph.

(2) For cases in which dependency has been dismissed pursuant to Section 366.3 or wardship has been terminated pursuant to subdivision (e) of Section 728, concurrently or subsequently to establishment of the guardianship, on or after July 1, 2011, or the date specified in the order described in paragraph (1) whichever is earlier, the rate paid shall not exceed the basic foster care maintenance payment rate as set forth in paragraph (1) of subdivision (g) of Section 11461.

(3) Beginning with the 2011–12 fiscal year, the Kin-GAP benefit payments rate structure shall be adjusted annually by the percentage change in the California Necessities Index, as set forth in paragraph (2) of subdivision (g) of Section 11461, without requiring a new agreement.

(4) In addition to the rate paid for a child eligible for a Kin-GAP payment, a specialized care increment, if applicable, as set forth in subdivision (e) of Section 11461, also shall be paid.

(5) In addition to the rate paid for a child eligible for a Kin-GAP payment, a clothing allowance, as set forth in subdivision (f) of Section 11461, also shall be paid.

(6) For a child eligible for a Kin-GAP payment who is a teen parent, the rate shall include the two hundred dollar ($200) monthly payment made to the relative caregiver in a whole family foster home pursuant to paragraph (3) of subdivision (d) of Section 11465.

~~(d)~~

(e) The county child welfare agency, probation department, or Indian tribe that entered into an agreement pursuant to Section 10553.1 shall provide the relative guardian with information, in writing, on the availability of the Kin-GAP program with an explanation of the difference between these benefits and Adoption

Assistance Program benefits and AFDC-FC benefits. The agency shall also provide the relative guardian with information on the availability of mental health services through the Medi-Cal program or other programs.

~~(e) The Kin-GAP agreement shall also specify the responsibility of the relative guardian for reporting changes in the needs of the child or the circumstances of the relative guardian that affect payment.~~

(f) The county child welfare agency, probation department, or Indian tribe, as appropriate, shall assess the needs of the child and the circumstances of the related guardian and is responsible for determining that the child meets the eligibility criteria for payment.

(g) Payments on behalf of a child who is a recipient of Kin-GAP benefits and who is also a consumer of regional center services shall be based on the rates established by the State Department of Social Services pursuant to Section 11464.

SEC. 48. Section 11387 of the Welfare and Institutions Code is amended to read:

11387. (a) In order to receive federal financial participation for payments under this article, the county child welfare agency or probation department or Indian tribe that entered into an agreement pursuant to Section 10553.1 shall negotiate and enter into a written, binding, kinship guardianship assistance agreement with the relative guardian of an eligible child, and provide the relative guardian with a copy of the agreement.

(b) The agreement shall specify, at a minimum, all of the following:

(1) The amount of and manner in which the kinship guardianship assistance payment will be provided under the agreement, *that the amount is subject to any applicable increases pursuant to cost-of-living adjustments established by statute* and the manner in which the agreement may be adjusted periodically, but no less frequently than every two years, in consultation with the relative guardian, based on the circumstances of the relative guardian and the needs of the child.

(2) Additional services and assistance for which the child and relative guardian will be eligible under the agreement.

(3) A procedure by which the relative guardian may apply for additional services, as needed, including, but not limited to, the

filing of a petition under Section 388 to have dependency jurisdiction resumed pursuant to subdivision (b) of Section 366.3.

~~(c)~~

(4) The agreement shall provide that it shall remain in effect regardless of the state of residency of the relative guardian.

(5) The responsibility of the relative guardian for reporting changes in the needs of the child or the circumstances of the relative guardian that affect payment.

~~(d)~~

(c) In accordance with the Kin-GAP agreement, the relative guardian shall be paid an amount of aid based on the child's needs otherwise covered in AFDC-FC payments and the circumstances of the relative guardian but that shall not exceed the foster care maintenance payment that would have been paid based on the age-related state-approved foster family home care rate and any applicable specialized care increment for a child placed in a licensed or approved family home pursuant to subdivisions (a) to (d), inclusive, of Section 11461. In addition, the rate paid for a child eligible for a Kin-GAP payment shall include an amount equal to the clothing allowance, as set forth in subdivision (f) of Section 11461, including any applicable rate adjustments. For a child eligible for a Kin-GAP payment who is a teen parent, the rate shall include the two hundred dollar ($200) monthly payment made to the relative caregiver in a whole family foster home pursuant to paragraph (3) of subdivision (d) of Section 11465.

(d) Commencing on the effective date of the act that added this subdivision, and notwithstanding subdivision (c), in accordance with the Kin-GAP agreement the relative guardian shall be paid an amount of aid based on the child's needs otherwise covered in AFDC-FC payments and the circumstances of the relative guardian, as follows:

(1) For cases in which the dependency has been dismissed pursuant to Section 366.3 or wardship has been terminated pursuant to subdivision (e) of Section 728, concurrently or subsequently to establishment of the guardianship, on or before June 30, 2011, or the date specified in a final order, for which the time to appeal has passed, issued by a court of competent jurisdiction in California State Foster Parent Association et al. v. William Lightbourne, et al. (U.S. Dist. Ct. No. C 07-05086 WHA), whichever is earlier, the rate paid shall not exceed the basic foster

care maintenance payment rate structure in effect prior to the effective date specified in the order described in this paragraph.

(2) For cases in which dependency has been dismissed pursuant to Section 366.3 or wardship has been terminated pursuant to subdivision (e) of Section 728, concurrently or subsequently to establishment of the guardianship, on or after July 1, 2011, or the date specified in the order described in paragraph (1), whichever is earlier, the rate paid shall not exceed the basic foster care maintenance payment rate as set forth in paragraph (1) of subdivision (g) of Section 11461.

(3) Beginning with the 2011–12 fiscal year, the Kin-GAP benefit payments rate structure shall be adjusted annually by the percentage change in the California Necessities Index, as set forth in paragraph (2) of subdivision (g) of Section 11461, without requiring a new agreement.

(4) In addition to the rate paid for a child eligible for a Kin-GAP payment, a specialized care increment, if applicable, as set forth in subdivision (e) of Section 11461, shall be paid.

(5) In addition to the rate paid for a child eligible for a Kin-GAP payment, a clothing allowance, as set forth in subdivision (f) of Section 11461, shall be paid.

(6) For a child eligible for a Kin-GAP payment who is a teen parent, the rate shall include the two hundred dollar ($200) monthly payment made to the relative caregiver in a whole family foster home pursuant to paragraph (3) of subdivision (d) of Section 11465.

(e) The county child welfare agency or probation department or Indian tribe that entered into an agreement pursuant to Section 10553.1 shall provide the relative guardian with information, in writing, on the availability of the federal Kin-GAP program with an explanation of the difference between these benefits and Adoption Assistance Program benefits and AFDC-FC benefits. The agency shall also provide the relative guardian with information on the availability of mental health services through the Medi-Cal program or other programs.

~~(f) The Kin-GAP agreement shall also specify the responsibility of the relative guardian for reporting changes in the needs of the child or the circumstances of the relative guardian that affect payment.~~

~~(g)~~

(f) The county child welfare agency, probation department, or Indian tribe, as appropriate, shall assess the needs of the child and the circumstances of the related guardian and is responsible for determining that the child meets the eligibility criteria for payment.

~~(h)~~

(g) Payments on behalf of a child who is a recipient of Kin-GAP benefits and who is also a consumer of regional center services shall be based on the rates established by the State Department of Social Services pursuant to Section 11464.

SEC. 49. Section 11405 of the Welfare and Institutions Code is amended to read:

11405. (a) AFDC-FC benefits shall be paid to an otherwise eligible child living with a nonrelated legal guardian, provided that the legal guardian cooperates with the county welfare department in all of the following:

(1) Developing a written assessment of the child's needs.

(2) Updating the assessment no less frequently than once every six months.

(3) Carrying out the case plan developed by the county.

(b) When AFDC-FC is applied for on behalf of a child living with a nonrelated legal guardian the county welfare department shall do all of the following:

(1) Develop a written assessment of the child's needs.

(2) Update those assessments no less frequently than once every six months.

(3) Develop a case plan that specifies how the problems identified in the assessment are to be addressed.

(4) Make visits to the child as often as appropriate, but in no event less often than once every six months.

(c) Where the child is a parent and has a child living with him or her in the same eligible facility, the assessment required by paragraph (1) of subdivision (a) shall include the needs of his or her child.

(d) Nonrelated legal guardians of eligible children who are in receipt of AFDC-FC payments described in this section shall be exempt from the requirement to register with the Statewide Registry of Private Professional Guardians pursuant to Sections 2850 and 2851 of the Probate Code.

(e) On and after January 1, 2012, a nonminor youth whose nonrelated guardianship was ordered in juvenile court pursuant to

Section 360 or 366.26, and whose dependency was dismissed, shall remain eligible for AFDC-FC benefits until the youth attains 19 years of age, effective January 1, 2013, until the youth attains 20 years of age, and effective January 1, 2014, until the youth attains 21 years of age, provided that the youth enters into a mutual agreement with the agency responsible for his or her guardianship, and the youth is meeting the conditions of eligibility, as described in Section 11403.

(f) (1) For cases in which a guardianship was established on or before June 30, 2011, or the date specified in a final order, for which the time for appeal has passed, issued by a court of competent jurisdiction in California State Foster Parent Association, et al v. William Lightbourne, et al. (U.S. Dist. Ct. No C 07-05086 WHA), whichever is earlier, the AFDC-FC payment described in this section shall be the foster family home rate structure in effect prior to the effective date specified in the order described in this paragraph.

(2) For cases in which guardianship has been established on or after July 1, 2011, or the date specified in the order described in paragraph (1), whichever is earlier, the AFDC-FC payments described in this section shall be the basic foster family home rate set forth in paragraph (1) of subdivision (g) of Section 11461.

(3) Beginning with the 2011–12 fiscal year, the AFDC-FC payments identified in this subdivision shall be adjusted annually by the percentage change in the California Necessities Index rate as set forth in paragraph (2) of subdivision (g) of Section 11461.

(g) In addition to the AFDC-FC rate paid, all of the following also shall be paid:

(1) A specialized care increment, if applicable, as set forth in subdivision (e) of Section 11461.

(2) A clothing allowance, as set forth in subdivision (f) of Section 11461.

(3) For a child eligible for an AFDC-FC payment who is a teen parent, the rate shall include the two hundred dollar ($200) monthly payment made to the relative caregiver in a whole family foster home pursuant to paragraph (3) of subdivision (d) of Section 11465.

SEC. 50. Section 11450.025 of the Welfare and Institutions Code is repealed.

~~11450.025. (a) Notwithstanding any other law, effective on June 1, 2011, or on the first day of the first month following 90 days after the effective date of the act that added this section, whichever is later, for all assistance units that do not include an aided adult, the computed aid grant of the assistance unit, as reduced by subdivision (b) of Section 11450.02, shall be further reduced pursuant to this section as follows:~~

~~(1) Commencing with the 61st cumulative month on aid, 5 percent.~~

~~(2) Commencing with the 73rd cumulative month on aid, 5 percent, for a total reduction of 10 percent of the computed aid grant.~~

~~(3) Commencing with the 85th cumulative month on aid, 5 percent, for a total reduction of 15 percent of the computed aid grant.~~

~~(b) Notwithstanding subdivision (a), the reductions provided for in this section shall not be applied when all of the parents or caretaker relatives of the aided child living in the home of the aided child are disabled and receiving benefits under Section 12200.~~

~~(c) All months of aid received on and after January 1, 1998, shall be counted for purposes of this section and shall be computed based on the cumulative time on aid of the member of the assistance unit who has received aid for the longest period.~~

SEC. 51. Section 11454 of the Welfare and Institutions Code, as amended by Section 26 of Chapter 8 of the Statutes of 2011, is amended to read:

11454. (a) A parent or caretaker relative shall not be eligible for aid under this chapter when he or she has received aid under this chapter ~~for a cumulative total of 48 months, or when he or she has received aid~~ *or* from any state under the Temporary Assistance for Needy Families program (Part A (commencing with Section 401) of Title IV of the federal Social Security Act (42 U.S.C. Sec. 601 et seq.)) for a cumulative total of ~~60~~ *48* months.

(b) (1) Except as otherwise specified in subdivision (c), Section 11454.5, or other provisions of law, all months of aid received under this chapter from January 1, 1998, to the operative date of this section, inclusive, shall be applied to the 48-month time limit described in subdivision (a).

(2) All months of aid received from ~~September 1, 1996~~ *January 1, 1998*, to the operative date of this section, inclusive, in any state

pursuant to the Temporary Assistance for Needy Families program (Part A (commencing with Section 401) of Title IV of the federal Social Security Act (42 U.S.C. Sec. 601 et seq.)), shall be applied to the ~~60-month~~ *48-month* time limit described in subdivision (a).

(c) Subdivision (a) and paragraph (1) of subdivision (b) shall not be applicable when all parents or caretaker relatives of the aided child who are living in the home of the child meet any of the following requirements:

(1) They are 60 years of age or older.

(2) They meet one of the conditions specified in paragraph (4) or (5) of subdivision (b) of Section 11320.3.

(3) They are not included in the assistance unit.

(4) They are receiving benefits under Section 12200 or Section 12300, State Disability Insurance benefits or Workers' Compensation Temporary Disability Insurance, if the disability significantly impairs the recipient's ability to be regularly employed or participate in welfare-to-work activities.

(5) They are incapable of maintaining employment or participating in welfare-to-work activities, as determined by the county, based on the assessment of the individual and the individual has a history of participation and full cooperation in welfare-to-work activities.

SEC. 52. Section 11454.2 of the Welfare and Institutions Code is amended to read:

11454.2. For purposes of making the transition to the requirements of the act that added this section, county welfare departments shall provide any assistance unit that includes a member who will reach the 48-month time limit described in subdivision (a) of Section 11454 before January 1, 2012~~, and any assistance unit that will receive a grant reduction pursuant to Section 11450.025 before January 1, 2012,~~ a notice of action 30 days prior to the date upon which the grant of the assistance unit will be reduced. This notice shall include a statement of the rights granted pursuant to Chapter 7 (commencing with Section 10950) of Part 2.

SEC. 53. Section 11461 of the Welfare and Institutions Code is amended to read:

11461. (a) For children or, on and after January 1, 2012, nonminor dependents placed in a licensed or approved family home with a capacity of six or less, or in an approved home of a

relative or nonrelated legal guardian, or the approved home of a nonrelative extended family member as described in Section 362.7, or, on and after January 1, 2012, a supervised independent living setting, as defined in subdivision (w) of Section 11400, the per child per month *basic* rates in the following schedule shall be in effect for the period July 1, 1989, through December 31, 1989:

Age	Basic rate
0–4	$ 294
5–8	319
9–11	340
12–14	378
15–20	412

(b) (1) Any county that, as of October 1, 1989, has in effect a basic rate that is at the levels set forth in the schedule in subdivision (a), shall continue to receive state participation, as specified in subdivision (c) of Section 15200, at these levels.

(2) Any county that, as of October 1, 1989, has in effect a basic rate that exceeds a level set forth in the schedule in subdivision (a), shall continue to receive the same level of state participation as it received on October 1, 1989.

(c) The amounts in the schedule of basic rates in subdivision (a) shall be adjusted as follows:

(1) Effective January 1, 1990, the amounts in the schedule of basic rates in subdivision (a) shall be increased by 12 percent.

(2) Effective May 1, 1990, any county that did not increase the basic rate by 12 percent on January 1, 1990, shall do both of the following:

(A) Increase the basic rate in effect December 31, 1989, for which state participation is received by 12 percent.

(B) Increase the basic rate, as adjusted pursuant to subparagraph (A), by an additional 5 percent.

(3) (A) Except as provided in subparagraph (B), effective July 1, 1990, for the 1990–91 fiscal year, the amounts in the schedule of basic rates in subdivision (a) shall be increased by an additional 5 percent.

(B) The rate increase required by subparagraph (A) shall not be applied to rates increased May 1, 1990, pursuant to paragraph (2).

(4) Effective July 1, 1998, the amounts in the schedule of basic rates in subdivision (a) shall be increased by 6 percent. Notwithstanding any other provision of law, the 6-percent increase provided for in this paragraph shall, retroactive to July 1, 1998, apply to every county, including any county to which paragraph (2) of subdivision (b) applies, and shall apply to foster care for every age group.

(5) Notwithstanding any other provision of law, any increase that takes effect after July 1, 1998, shall apply to every county, including any county to which paragraph (2) of subdivision (b) applies, and shall apply to foster care for every age group.

(6) The increase in the basic foster family home rate shall apply only to children placed in a licensed foster family home receiving the basic rate or in an approved home of a relative or nonrelative extended family member, as described in Section 362.7, a supervised independent living setting, as defined in subdivision (w) of Section 11400, or a nonrelated legal guardian receiving the basic rate. The increased rate shall not be used to compute the monthly amount that may be paid to licensed foster family agencies for the placement of children in certified foster homes.

(d) (1) (A) Beginning with the 1991–92 fiscal year, the schedule of basic rates in subdivision (a) shall be adjusted by the percentage changes in the California Necessities Index, computed pursuant to the methodology described in Section 11453, subject to the availability of funds.

(B) In addition to the adjustment in subparagraph (A) effective January 1, 2000, the schedule of basic rates in subdivision (a) shall be increased by 2.36 percent rounded to the nearest dollar.

(C) Effective January 1, 2008, the schedule of basic rates in subdivision (a), as adjusted pursuant to subparagraph (B), shall be increased by 5 percent, rounded to the nearest dollar. The increased rate shall not be used to compute the monthly amount that may be paid to licensed foster family agencies for the placement of children in certified foster family homes, and shall not be used to recompute the foster care maintenance payment that would have been paid based on the age-related, state-approved foster family home care rate and any applicable specialized care increment, for any adoption assistance agreement entered into prior to October 1, 1992, or in any subsequent reassessment for adoption assistance agreements executed before January 1, 2008.

(2) (A) Any county that, as of the 1991–92 fiscal year, receives state participation for a basic rate that exceeds the amount set forth in the schedule of basic rates in subdivision (a) shall receive an increase each year in state participation for that basic rate of one-half of the percentage adjustments specified in paragraph (1) until the difference between the county's adjusted state participation level for its basic rate and the adjusted schedule of basic rates is eliminated.

(B) Notwithstanding subparagraph (A), all counties for the 1999–2000 fiscal year and the 2007–08 fiscal year shall receive an increase in state participation for the basic rate of the entire percentage adjustment described in paragraph (1).

(3) If a county has, after receiving the adjustments specified in paragraph (2), a state participation level for a basic rate that is below the amount set forth in the adjusted schedule of basic rates for that fiscal year, the state participation level for that rate shall be further increased to the amount specified in the adjusted schedule of basic rates.

(e) (1) As used in this section, "specialized care increment" means an approved amount paid with state participation on behalf of an AFDC-FC child requiring specialized care to a home listed in subdivision (a) in addition to the basic rate. Notwithstanding subdivision (a), the specialized care increment shall not be paid to a nonminor dependent placed in a supervised independent living setting as defined in subdivision (w) of Section 11403. On the effective date of this section, the department shall continue and maintain the current ratesetting system for specialized care.

(2) Any county that, as of the effective date of this section, has in effect specialized care increments that have been approved by the department, shall continue to receive state participation for those payments.

(3) Any county that, as of the effective date of this section, has in effect specialized care increments that exceed the amounts that have been approved by the department, shall continue to receive the same level of state participation as it received on the effective date of this section.

(4) (A) Except for subparagraph (B), beginning January 1, 1990, specialized care increments shall be adjusted in accordance with the methodology for the schedule of basic rates described in subdivisions (c) and (d). No county shall receive state participation

for any increases in a specialized care increment which exceeds the adjustments made in accordance with this methodology.

(B) Notwithstanding subdivision (e) of Section 11460, for the 1993–94 fiscal year, an amount equal to 5 percent of the State Treasury appropriation for family homes shall be added to the total augmentation for the AFDC-FC program in order to provide incentives and assistance to counties in the area of specialized care. This appropriation shall be used, but not limited to, encouraging counties to implement or expand specialized care payment systems, to recruit and train foster parents for the placement of children with specialized care needs, and to develop county systems to encourage the placement of children in family homes. It is the intent of the Legislature that in the use of these funds, federal financial participation shall be claimed whenever possible.

(C) (i) Notwithstanding subparagraph (A), the specialized care increment shall not receive a cost-of-living adjustment in the 2011–12 or 2012–13 fiscal years.

(ii) Notwithstanding clause (i), a county may choose to apply a cost-of-living adjustment to its specialized care increment during the 2011–12 or 2012–13 fiscal years. To the extent that a county chooses to apply a cost-of-living adjustment during that time, the state shall not participate in the costs of that adjustment.

(iii) To the extent that federal financial participation is available for a cost-of-living adjustment made by a county pursuant to clause (ii), it is the intent of the Legislature that the federal funding shall be utilized.

(f) (1) As used in this section, "clothing allowance" means the amount paid with state participation in addition to the basic rate for the provision of additional clothing for an AFDC-FC child, including, but not limited to, an initial supply of clothing and school or other uniforms.

(2) Any county that, as of the effective date of this section, has in effect clothing allowances, shall continue to receive the same level as it received on the effective date of this section.

(3) (A) Commencing in the 2007–08 fiscal year, for children whose foster care payment is the responsibility of Colusa, Plumas, and Tehama Counties, the amount of the clothing allowance may be up to two hundred seventy-four dollars ($274) per child per year.

(B) Each county listed in subparagraph (A) that elects to receive the clothing allowance shall submit a Clothing Allowance Program Notification to the department within 60 days after the effective date of the act that adds this paragraph.

(C) The Clothing Allowance Program Notification shall identify the specific amounts to be paid and the disbursement schedule for these clothing allowance payments.

(4) *(A)* Beginning January 1, 1990, except as provided in paragraph (5), clothing allowances shall be adjusted annually in accordance with the methodology for the schedule of basic rates described in subdivisions (c) and (d). No county shall be reimbursed for any increases in clothing allowances which exceed the adjustments made in accordance with this methodology.

(B) (1) Notwithstanding subparagraph (A), the clothing allowance shall not receive any cost-of-living adjustment in the 2011–12 or 2012–13 fiscal years.

(2) Notwithstanding paragraph (1), a county may choose to apply a cost of living adjustment to its clothing allowance during the 2011–12 or 2012–13 fiscal years. To the extent that a county chooses to apply a cost-of-living adjustment during that time, the state shall not participate in the costs of that adjustment.

(3) To the extent that federal financial participation is available for a cost-of-living adjustment made by a county pursuant to paragraph (2), it is the intent of the Legislature that the federal funding shall be utilized.

(5) *(A)* For the 2000–01 fiscal year and each fiscal year thereafter, without a county share of cost, notwithstanding subdivision (c) of Section 15200, each child shall be entitled to receive a supplemental clothing allowance of one hundred dollars ($100) per year subject to the availability of funds. The clothing allowance shall be used to supplement, and not supplant, the clothing allowance specified in paragraph (1).

(B) Notwithstanding subparagraph (A), the state shall no longer participate in the supplemental clothing allowance commencing with the 2011–12 fiscal year.

(g) (1) Notwithstanding subdivisions (a) to (d), inclusive, for a child, or on and after January 1, 2012, a nonminor dependent, placed in a licensed or approved family home with a capacity of six or less, or placed in an approved home of a relative or the approved home of a nonrelative extended family member as

described in Section 362.7, or placed on and after January 1, 2012, in a supervised independent living setting, as defined in subdivision (w) of Section 11400, the per child per month basic rate in the following schedule shall be in effect for the period commencing July 1, 2011, or the date specified in the final order, for which the time to appeal has passed, issued by a court of competent jurisdiction in California State Foster Parent Association v. William Lightbourne, et al.(U.S. Dist. Ct C 07-08056 WHA), whichever is earlier, through June 30, 2012:

Age	*Basic rate*
0–4	*$ 609*
5–8	*$ 660*
9–11	*$ 695*
12–14	*$ 727*
15–20	*$ 761*

(2) Commencing July 1, 2011, the basic rate set forth in this subdivision shall be annually adjusted on July 1 by the annual percentage change in the California Necessities Index applicable to the calendar year within which each July 1 occurs.

(3) Subdivisions (e) and (f) shall apply to payments made pursuant to this subdivision.

SEC. 54. Section 11462.04 of the Welfare and Institutions Code is amended to read:

11462.04. (a) (1) Notwithstanding any other ~~provision of~~ law, no new group home rate or change to an existing rate shall be established pursuant to Section 11462. ~~No~~ *An* application shall *not* be accepted or processed for any of the following:

(A) A new program.

(B) A new provider.

(C) A program change, such as a rate classification level increase.

(D) A program capacity increase.

(E) A program reinstatement.

(2) Notwithstanding paragraph (1), the department may grant exceptions as appropriate on a case-by-case basis, based upon a written request and supporting documentation provided by county placing agencies, including county welfare or probation directors.

(b) Immediately prior to the inoperative date of this section, the department shall provide feedback regarding the implementation of this section to the Legislature.

(c) This section shall become inoperative ~~one year after the effective date of the act that adds this section, and on January 1, 2012,~~ *on January 1, 2013, and as of that date* is repealed, unless a later enacted statute, that becomes operative before January 1, ~~2012~~ *2013*, deletes or extends ~~the dates on which it becomes inoperative and is repealed~~ *that date.*

SEC. 55. Section 11465 of the Welfare and Institutions Code is amended to read:

11465. (a) When a child is living with a parent who receives AFDC-FC or Kin-GAP benefits, the rate paid to the provider on behalf of the parent shall include an amount for care and supervision of the child.

(b) For each category of eligible licensed community care facility, as defined in Section 1502 of the Health and Safety Code, the department shall adopt regulations setting forth a uniform rate to cover the cost of care and supervision of the child in each category of eligible licensed community care facility.

(c) (1) On and after July 1, 1998, the uniform rate to cover the cost of care and supervision of a child pursuant to this section shall be increased by 6 percent, rounded to the nearest dollar. The resultant amounts shall constitute the new uniform rate.

(2) (A) On and after July 1, 1999, the uniform rate to cover the cost of care and supervision of a child pursuant to this section shall be adjusted by an amount equal to the California Necessities Index computed pursuant to Section 11453, rounded to the nearest dollar. The resultant amounts shall constitute the new uniform rate, subject to further adjustment pursuant to subparagraph (B).

(B) In addition to the adjustment specified in subparagraph (A), on and after January 1, 2000, the uniform rate to cover the cost of care and supervision of a child pursuant to this section shall be increased by 2.36 percent, rounded to the nearest dollar. The resultant amounts shall constitute the new uniform rate.

(3) Subject to the availability of funds, for the 2000–01 fiscal year and annually thereafter, these rates shall be adjusted for cost of living pursuant to procedures in Section 11453.

(4) On and after January 1, 2008, the uniform rate to cover the cost of care and supervision of a child pursuant to this section shall

be increased by 5 percent, rounded to the nearest dollar. The resulting amount shall constitute the new uniform rate.

(d) (1) Notwithstanding subdivisions (a) to (c), inclusive, the payment made pursuant to this section for care and supervision of a child who is living with a teen parent in a whole family foster home, as defined in Section 11400, shall equal the basic rate for children placed in a licensed or approved home as specified in subdivisions (a) to (d), inclusive, *and subdivision (g),* of Section 11461.

(2) The amount paid for care and supervision of a dependent infant living with a dependent teen parent receiving AFDC-FC benefits in a group home placement shall equal the infant supplement rate for group home placements.

(3) The caregiver shall provide the county child welfare agency or probation department with a copy of the shared responsibility plan developed pursuant to Section 16501.25 and shall advise the county child welfare agency or probation department of any subsequent changes to the plan. Once the plan has been completed and provided to the appropriate agencies, the payment made pursuant to this section shall be increased by an additional two hundred dollars ($200) per month to reflect the increased care and supervision while he or she is placed in the whole family foster home.

(4) In any year in which the payment provided pursuant to this section is adjusted for the cost of living as provided in paragraph (1) of subdivision (c), the payments provided for in this subdivision shall also be increased by the same procedures.

(5) A Kin-GAP relative who, immediately prior to entering the Kin-GAP program, was designated as a whole family foster home shall receive the same payment amounts for the care and supervision of a child who is living with a teen parent they received in foster care as a whole family foster home.

(6) On and after January 1, 2012, the rate paid for a child living with a teen parent in a whole family foster home as defined in Section 11400 shall also be paid for a child living with a nonminor dependent parent who is eligible to receive AFDC-FC or Kin-GAP pursuant to Section 11403.

SEC. 56. Section 11466.23 of the Welfare and Institutions Code is amended to read:

11466.23. (a) It is the intent of the Legislature to comply with the federal requirements of the Improper Payments Act of 2002 with respect to the remittance of the federal share of foster care overpayments.

(b) For the purposes of this section, ~~a federal~~ "*federal* foster care or adoption assistance ~~overpayment is defined as~~ *overpayment" means* any amount of aid paid to which a foster care provider or adoption assistance recipient was not entitled, including any overpayment identified by a foster care provider as described in Section 11400, or federal Adoption Assistance Program recipient as described in Chapter 2.1 (commencing with Section 16115) of Part 4, and on and after the date that the director executes a declaration pursuant to Section 11217, any federal Kin-GAP aid paid to which a related guardian was not entitled, including any overpayment identified by a federal Kin-GAP recipient as described in Article 4.7 (commencing with Section 11385).

(c) Counties shall be required to remit the appropriate amount of federal funds upon identification of the overpayment, following the completion of due process.

(1) Counties shall not be required to repay the overpayment when any of the following occurs:

(A) The amount is legally uncollectible, including any amount legally uncollectible pursuant to Section 11466.24.

(B) The cost of collection exceeds the overpayment.

(C) The foster family agency or group home is no longer in business or licensed by the department.

~~(2) Remittance of overpayments of federal AFDC-FC funds, federal Kin-GAP, and federal AAP funds not excluded by paragraph (1) shall be shared by the state and the counties based on a 40-percent state, 60-percent county sharing ratio. Upon actual collection of any overpayments from providers or recipients, the county shall ensure that the total amount reimbursed to the state reflects the federal and state share of the overpayment costs, as specified. All overpayments of federal AFDC-FC funds, federal Kin-GAP, and federal AAP funds included in paragraph (1) shall be repaid completely with state funds.~~

(2) Remittance of overpayments of federal AFDC-FC, federal Kin-GAP, and federal AAP funds not excluded by paragraph (1)

shall be shared by the state and the counties based on the following sharing ratios:

(A) For federal AFDC-FC funds, the sharing ratios described in subdivision (c) of Section 15200.

(B) For federal Kin-GAP funds, the sharing ratios described in Section 10101.2.

(C) For federal AAP funds, the sharing ratios described in subdivision (e) of Section 15200.

(3) Upon actual collection of any overpayments from providers or recipients, the county shall ensure that the total amount reimbursed to the state reflects the federal and state share of the overpayment costs, as specified. All overpayments of federal AFDC-FC, federal Kin-GAP, and federal AAP funds included in paragraph (1) shall be repaid completely with state funds.

~~(3)~~

(4) Nothing in this section shall inhibit existing county authority to collect overpayments.

~~(4)~~

(5) Nothing in this section shall inhibit existing county responsibility to remit voluntary overpayments upon collection.

(d) (1) The department shall adopt regulations to implement this section by December 31, 2008. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, in consultation and coordination with the County Welfare Directors Association, may adopt emergency regulations to implement this section.

(2) The adoption of emergency regulations pursuant to subdivision (a) shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and shall remain in effect for no more than 180 days, by which time final regulations shall be adopted.

(e) The department may only require counties to remit payment of the federal share for overpayments upon identification that occur on or after the effective date of regulations adopted pursuant to this section.

SEC. 57. Section 11487 of the Welfare and Institutions Code is amended to read:

11487. (a) Whenever any aid under this chapter is repaid to the state *by means of child support collections*, the state shall be entitled to the amount received or recovered, except to the extent that county and federal funds were expended. If funds advanced by the federal government were paid, the federal government shall be entitled to a share of the amount received or recovered, proportionate to the amount of federal funds paid. Except as provided in subdivision (b), if funds were paid by a county, the county shall be entitled to a share of the amount received or recovered, proportionate to the amount of county funds paid.

(b) For the 2011–12 fiscal year, the county share of funds received or recovered pursuant to subdivision (a) shall instead be suspended and these funds shall be retained by the state.

SEC. 58. Section 11487.1 is added to the Welfare and Institutions Code, to read:

11487.1. Except as provided in Sections 11457 and 11487, whenever any aid under this chapter is repaid to a county or recovered by a county, the state shall be entitled to a share of the amount received or recovered, proportionate to the amount of state funds paid, and, if funds advanced by the federal government were paid, the federal government shall be entitled to a share of the amount received or recovered, proportionate to the amount of federal funds paid.

SEC. 59. Section 12200.03 of the Welfare and Institutions Code is amended to read:

12200.03. (a) Notwithstanding any other law, and subject to subdivision (b), on the first day of the first month following 90 days after the effective date of the act that adds this section, the maximum aid payment for an individual, as specified in Section 12200, except subdivisions (e), (g), and (h) of that section, shall be reduced to equal the minimum amount required by the federal Social Security Act in order to maintain eligibility for federal funding under Title XIX of the federal Social Security Act, contained in Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(b) Notwithstanding subdivision (a), in no event shall the payment schedules be reduced below the level of the state's March 1983 payment standards, as adjusted by the federal Social Security Administration, pursuant to Section 416.2096(b) of Title 20 of the Code of Federal Regulations.

SEC. 60. Section 12301.03 of the Welfare and Institutions Code is amended to read:

12301.03. (a) (1) ~~Notwithstanding~~ *The Legislature finds and declares as follows:*

(A) Authorized hours under the In-Home Supportive Services program were reduced in the 1992–93 fiscal year, and included a supplemental assessment process that was intended to ensure that recipients remained safely in their homes.

(B) The reduction in authorized hours as provided for in Chapter 8 of the Statutes of 2011 includes a supplemental assessment process, that is similarly intended to ensure that recipients remain safely in their homes.

(2) Notwithstanding any other provision of law, if the Department of Finance determines that a reduction in authorized hours of service is necessary, pursuant to subdivision (d) of Section 14132.957, the department shall implement a reduction in authorized hours of service to each in-home supportive services recipient as specified in this section, which shall be applied to the recipient's hours as authorized pursuant to his or her most recent assessment.

~~(2)~~

(3) The reduction required by this section shall not preclude any reassessment to which a recipient would otherwise be entitled. However, hours authorized pursuant to a reassessment shall be subject to the reduction required by this section.

~~(3)~~

(4) For those recipients who have a documented unmet need, excluding protective supervision, because of the limitations contained in Section 12303.4, this reduction shall be applied first to the unmet need before being applied to the authorized hours. If the recipient believes he or she will be at serious risk of out-of-home placement as a consequence of the reduction, the recipient may apply for a restoration of the reduction of authorized service hours, pursuant to Section 12301.05.

~~(4)~~

(5) A recipient of services under this article may direct the manner in which the reduction of hours is applied to the recipient's previously authorized services.

(6) The reduction in service hours made pursuant to paragraph (2) shall not apply to in-home supportive services recipients who

also receive services under Section 9560, subdivision (t) of Section 14132, and Section 14132.99.

(b) The department shall work with the counties to develop a process to allow for counties to preapprove IHSS Care Supplements described in Section 12301.05, to the extent that the process is permissible under federal law. The preapproval process shall be subject to the following conditions:

(1) The preapproval process shall rely on the criteria for assessing IHSS Supplemental Care applications, developed pursuant to Section 12301.05.

(2) Preapproval shall be granted only to individuals who would otherwise be granted a full restoration of their hours pursuant to Section 12301.05.

(3) With respect to existing recipients as of the effective date of this section, all efforts shall be made to ensure that counties complete the process on or before a specific date, as determined by the department, in consultation with counties in order to allow for the production, printing, and mailing of notices to be issued to remaining recipients who are not granted preapproval and who thereby are subject to the reduction pursuant to this section.

(4) The department shall work with counties to determine how to apply a preapproval process with respect to new applicants to the IHSS program who apply after the effective date of this section.

(c) The notice of action informing each recipient who is not preapproved for an IHSS Care Supplement pursuant to subdivision (b) shall be mailed at least 15 days prior to the reduction going into effect. The notice of action shall be understandable to the recipient and translated into all languages spoken by a substantial number of the public served by the In-Home Supportive Services program, in accordance with Section 7295.2 of the Government Code. The notice shall not contain any recipient financial or confidential identifying information other than the recipient's name, address, and Case Management Information and Payroll System (CMIPS) client identification number, and shall include, but not be limited to, all of the following information:

(1) The aggregate number of authorized hours before the reduction pursuant to *paragraph (2) of* subdivision (a) and the aggregate number of authorized hours after the reduction.

(2) That the recipient may direct the manner in which the reduction of authorized hours is applied to the recipient's previously authorized services.

(3) How all or part of the reduction may be restored, as set forth in Section 12301.05, if the recipient believes he or she will be at serious risk of out-of-home placement as a consequence of the reduction.

(d) The department shall inform providers of any reduction to recipient hours through a statement on provider timesheets, after consultation with counties.

(e) The IHSS Care Supplement application process described in Section 12301.05 shall be completed before a request for a state hearing is submitted. If the IHSS Care Supplement application is filed within 15 days of the notice of action required by subdivision (c), or before the effective date of the reduction, the recipient shall be eligible for aid paid pending. A revised notice of action shall be issued by the county following evaluation of the IHSS Care Supplement application.

(f) (1) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement and administer this section through all-county letters or similar instruction from the department until regulations are adopted. The department shall adopt emergency regulations implementing this section no later than October 1, 2013. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no

more than 180 days, by which time final regulations may be adopted.

(g) If the Director of Health Care Services determines that federal approval is necessary to implement this section, Section 12301.05, or both, these sections shall be implemented only after any state plan amendments required pursuant to Section 14132.95 are approved.

~~(g)~~

(h) This section shall become operative on the first day of the first month following 90 days after the effective date of ~~the act that added this section~~ *Chapter 8 of the Statutes of 2011*, or October 1, 2012, whichever is later.

SEC. 61. Section 12301.05 of the Welfare and Institutions Code is amended to read:

12301.05. (a) Any aged, blind, or disabled individual who is eligible for services under this chapter who receives a notice of action indicating that his or her services will be reduced under subdivision (a) of Section 12301.03 but who believes he or she is at serious risk of out-of-home placement unless all or part of the reduction is restored may submit an IHSS Care Supplement application. When a recipient submits an IHSS Care Supplement application within 15 days of receiving the reduction notice or prior to the implementation of the reduction, the recipient's in-home supportive services shall continue at the level authorized by the most recent assessment, prior to any reduction, until the county finds that the recipient does or does not require restoration of any hours through the IHSS Care Supplement. If the recipient disagrees with the county's determination concerning the need for the IHSS Care Supplement, the recipient may request a hearing on that determination.

(b) The department shall develop an assessment tool, in consultation with stakeholders, to be used by the counties to determine if a recipient is at serious risk of out-of-home placement as a consequence of the reduction of services pursuant to section 12301.03. The assessment tool shall be developed utilizing standard of care criteria for relevant out-of-home placements that serve individuals who are aged, blind, or who have disabilities and who would qualify for IHSS if living at home, including, but not limited to, criteria set forth in Chapter 7.0 of the Manual of Criteria for Medi-Cal Authorization published by the State Department of

Health Care Services, as amended April 15, 2004, and the IHSS uniform assessment guidelines.

(c) Counties shall give a high priority to prompt screening of persons specified in this section to determine their need for an IHSS Care Supplement.

(d) (1) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement and administer this section through all-county letters or similar instruction from the department until regulations are adopted. The department shall adopt emergency regulations implementing this section no later than October 1, 2013. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State, and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

~~(e) If the Director of Health Care Services determines that federal approval is needed to implement this section, this section shall not be implemented until after any state plan amendments, pursuant to Section 14132.95, are received.~~

~~(f)~~

(e) This section shall become operative on the first day of the first month following 90 days after the effective date of ~~the act that added this section~~ *Chapter 8 of the Statutes of 2011*, or October 1, 2012, whichever is later.

SEC. 62. Section 12309.1 of the Welfare and Institutions Code is amended to read:

12309.1. (a) As a condition of receiving services under this article, or Section 14132.95 or 14132.952, an applicant for or recipient of services shall obtain a certification from a licensed health care professional, including, but not limited to, a physician, physician assistant, regional center clinician or clinician supervisor, occupational therapist, physical therapist, psychiatrist, psychologist, optometrist, ~~opthamologist~~ *ophthalmologist*, or public health nurse, declaring that the applicant or recipient is unable to perform some activities of daily living independently, and that without services to assist him or her with activities of daily living, the applicant or recipient is at risk of placement in out-of-home care.

(1) For purposes of this section, a licensed health care professional means an individual licensed in California by the appropriate California regulatory agency, acting within the scope of his or her license or certificate as defined in the Business and Professions Code.

(2) Except as provided in subparagraph (A) or (B) or subdivision (c), the certification shall be received prior to service authorization, and services shall not be authorized in the absence of the certification.

(A) Services may be authorized prior to receipt of the certification when the services have been requested on behalf of an individual being discharged from a hospital or nursing home and services are needed to enable the individual to return safely to their home or into the community.

(B) Services may be authorized ~~prior to~~ *temporarily pending* receipt of the certification when the ~~deterioration of the recipient's health or mental health is likely to result in eviction from home, homelessness, or a hazardous living environment~~ *county determines that there is a risk of out-of-home placement*.

(3) The county shall consider the certification as one indicator of the need for in-home supportive services, but the certification shall not be the sole determining factor.

(4) The health care professional's certification shall include, at a minimum, both of the following:

(A) A statement by the professional, as defined in subdivision (a), that the individual is unable to independently perform one or more activities of daily living, and that one or more of the services available under the IHSS program is recommended for the

applicant or recipient, in order to prevent the need for out-of-home care.

(B) A description of any condition or functional limitation that has resulted in, or contributed to, the applicant's or recipient's need for assistance.

(b) The department, in consultation with the State Department of Health Care Services and with stakeholders, including, but not limited to, representatives of program recipients, providers, and counties, shall develop a standard certification form for use in all counties that includes, but is not limited to, all of the conditions in paragraph (4) of subdivision (a). The form shall include a description of the In-Home Supportive Services program and the services the program can provide when authorized after a social worker's assessment of eligibility. The form shall not, however, require health care professionals to certify the applicant's or recipient's need for each individual service.

(c) The department, in consultation with the State Department of Health Care Services and stakeholders, as defined in subdivision (b), shall identify alternative documentation that shall be accepted by counties to meet the requirements of this section, including, but not limited to, hospital or nursing facility discharge plans, minimum data set forms, individual program plans, or other documentation that contains the necessary information, consistent with the requirements specified in subdivision (a).

(d) The department shall develop a letter for use by counties to inform recipients of the requirements of subdivision (a). The letter shall be understandable to the recipient, and shall be translated into all languages spoken by a substantial number of the public served by the In-Home Supportive Services program, in accordance with Section 7295.2 of the Government Code.

(e) This section shall not apply to a recipient who is receiving services in accordance with this article or Section 14132.95 or 14132.952 on the operative date of this section until the date of the recipient's first reassessment following the operative date of this section, as provided in subdivision (f).

(1) The recipient shall be notified of the certification requirement before or at the time of the reassessment, and shall submit the certification within 45 days following the reassessment in order to continue to be authorized for receipt of services.

(2) A county may extend the 45-day period for a recipient to submit the medical certification on a case-by-case basis, if the county determines that good cause for the delay exists.

(f) This section shall become operative on the first day of the first month following 90 days after the effective date of ~~the act that added this section~~ *Chapter 8 of the Statutes of 2011*, or July 1, 2011, whichever is later.

(g) The State Department of Health Care Services shall provide notice to all Medi-Cal managed care plans, directing the plans to assess all Medi-Cal recipients applying for or receiving in-home supportive services, in order to make the certifications required by this section.

(h) If the Director of Health Care Services determines that a Medicaid State Plan amendment is necessary to implement subdivision (b) of Section 14132.95, this section shall not be implemented until federal approval is received.

SEC. 63. Section 14021.30 is added to the Welfare and Institutions Code, to read:

14021.30. (a) It is the intent of the Legislature to transfer to the State Department of Health Care Services, no later than July 1, 2012, the administration of the Drug Medi-Cal program from the State Department of Alcohol and Drug Programs. It is further the intent of the Legislature that this transfer should happen efficiently and effectively, with no unintended interruptions in service delivery. This transfer is intended to do all of the following:

(1) Improve access to alcohol and drug treatment services, including a focus on recovery and rehabilitation services.

(2) More effectively integrate the financing of services, including the receipt of federal funds.

(3) Improve state accountability and outcomes.

(4) Provide focused, high-level leadership for behavioral health services.

(b) Effective July 1, 2012, the administrative functions for the Drug Medi-Cal program that were previously performed by the State Department of Alcohol and Drug Programs are transferred to the department.

(c) Notwithstanding subdivision (b), the department and the State Department of Alcohol and Drug Programs may conduct transition activities prior to July 1, 2012, that are necessary to ensure the efficient and effective transfer of Drug Medi-Cal

program functions by that date in accordance with the transition plan described in Section 14021.31.

SEC. 64. Section 14021.31 is added to the Welfare and Institutions Code, to read:

14021.31. (a) The department, in collaboration with the State Department of Alcohol and Drug Programs, shall develop an administrative and programmatic transition plan to guide the transfer of the Drug Medi-Cal program to the department effective July 1, 2012.

(1) Commencing no later than July 15, 2011, the department, together with the State Department of Alcohol and Drug Programs, shall convene stakeholders to receive input from consumers, family members, providers, counties, and representatives of the Legislature concerning the transfer of the administration of Drug Medi-Cal functions currently performed by the State Department Alcohol and Drug Programs to the department. This consultation shall inform the creation of an administrative and programmatic transition plan that shall include, but is not limited to, the following components:

(A) Plans for how to review monthly billing from counties to monitor and prevent any disruptions of service to Drug Medi-Cal beneficiaries during and immediately after the transition, and a description of how the department intends to approach the longer-term development of measures for access and quality of service.

(B) A detailed description of the Drug Medi-Cal administrative functions currently performed by the State Department of Alcohol and Drug programs.

(C) Explanations of the operational steps, timelines, and key milestones for determining when and how each of these functions will be transferred. These explanations shall also be developed for the transition of position and staff serving the Drug Medi-Cal program and how these will relate to and align with positions for the Medi-Cal program at the department. The department shall consult with the Department of Personnel Administration in developing this aspect of the transition plan.

(D) A list of any planned or proposed changes or efficiencies in how the functions will be performed, including the anticipated fiscal and programmatic impacts of the changes.

(E) A detailed organization chart that reflects the planned staffing at the department, taking into account the requirements of subparagraphs (A) to (C), inclusive, and includes focused, high-level leadership for behavioral health issues.

(F) A description of how stakeholders were included in the initial planning process to formulate the transition plan, and a description of how their feedback will be taken into consideration after transition activities are underway.

(2) The department, together with the State Department of Alcohol and Drug Programs, shall convene and consult with stakeholders at least once following production of a draft of the transition plan and before submission of that plan to the Legislature. Continued consultation with stakeholders shall occur in accordance with the requirement in subparagraph (F) of paragraph (1).

(3) The department shall provide the transition plan described in paragraph (1) to all fiscal committees and appropriate policy committees of the Legislature by October 1, 2011, and shall provide additional updates to the Legislature during budget subcommittee hearings after that date, as necessary.

(b) The requirement for submitting a report imposed under paragraph (3) of subdivision (a) is inoperative on October 1, 2015, pursuant to Section 10231.5 of the Government Code.

SEC. 65. Section 14132.97 of the Welfare and Institutions Code is amended to read:

14132.97. (a) (1) For purposes of this section, "waiver personal care services" means personal care services authorized by the department for persons who are eligible for either nursing or model nursing facility waiver services.

(2) Waiver personal care services shall satisfy all of the following criteria:

(A) The services shall be defined in the nursing and model nursing facility waivers.

(B) The services shall differ in scope from services that may be authorized under Section 14132.95 or 14132.952.

(C) The services shall not replace any hours of services authorized or that may be authorized under Section 14132.95 or 14132.952.

~~(D) The services shall not replace any hours of service reduced under Sections 12301.03 and 12301.06, or any other state law that reduces hours of service under Section 14132.95 or 14132.952.~~

(b) An individual may receive waiver personal care services if all of the following conditions are met:

(1) The individual has been approved by the department to receive services in accordance with a waiver approved under Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) for persons who would otherwise require care in a nursing facility.

(2) The individual has doctor's orders that specify that he or she requires waiver personal care services in order to remain in his or her own home.

(3) The individual chooses, either personally or through a substitute decisionmaker who is recognized under state law for purposes of giving consent for medical treatment, to receive waiver personal care services, as well as medically necessary skilled nursing services, in order to remain in his or her own home.

(4) The waiver personal care services and all other waiver services for the individual do not result in costs that exceed the fiscal limit established under the waiver.

(c) The department shall notify the administrator of the in-home supportive services program in the county of residence of any individual who meets all requirements of subdivision (b) and has been authorized by the department to receive waiver personal care services. The county of residence shall then do the following:

(1) Inform the department of the services that the individual is authorized to receive under Section 14132.95 or 14132.952 at the time he or she becomes eligible for waiver personal care services.

(2) Determine the individual's eligibility for services under Section 14132.95 or 14132.952 if he or she is not currently authorized to receive those services and if he or she has not been previously determined eligible for those services.

(3) Implement the department's authorization for waiver personal care services for the individual at the quantity and scope authorized by the department.

(d) (1) Waiver personal care services approved by the department for individuals who meet the requirements of subdivision (b) may be provided in either of the following ways, or a combination of both:

(A) By a licensed and certified home health agency participating in the Medi-Cal program.

(B) By one or more providers of personal care services under Article 7 (commencing with Section 12300) of Chapter 3 and subdivision (d) of Section 14132.95, when the individual elects, in writing, to utilize these service providers.

(2) The department shall approve waiver personal care services for individuals who meet the requirements of subdivision (b) only when the department finds that the individual's receipt of waiver personal care services is necessary in order to enable the individual to be maintained safely in his or her own home and community.

(3) When waiver personal care services are provided by a licensed and certified home health agency, the home health agency shall receive payment in the manner by which it would receive payment for any other service approved by the department.

(4) When waiver personal care services are provided by one or more providers of personal care services under Article 7 (commencing with Section 12300) of Chapter 3 and subdivision (d) of Section 14132.95, the providers shall receive payment on a schedule and in a manner by which providers of personal care services receive payment. The State Department of Social Services shall commence making payments for waiver personal care services when its payment system has been modified to accommodate those payments. No county shall be obligated to administer waiver personal care services until the State Department of Social Services payment system has been modified to accommodate those payments. However, any county or public authority or nonprofit consortium that administers the in-home supportive services program and personal care services program may pay providers for the delivery of waiver personal care services if it chooses to do so. In such a case, the county, public authority, or nonprofit consortium shall be reimbursed by the department for the waiver personal care services authorized by the department and provided to an individual upon submittal of documentation as required by the waiver, and in accordance with the requirements of the department.

(e) Waiver personal care services shall not count as alternative resources in a county's determination of the amount of services an individual may receive under Section 14132.95 or 14132.952.

(f) Any administrative costs to the State Department of Social Services, a county, or a public authority or nonprofit consortium associated with implementing this section shall be considered administrative costs under the waiver and shall be reimbursed by the department.

(g) Two hundred fifty thousand dollars ($250,000) is appropriated from the General Fund to the State Department of Social Services for the 1998–99 fiscal year for the purpose of making changes to the case management, information, and payrolling system that are necessary for the implementation of this section.

(h) This section shall not be implemented until the department has obtained federal approval of any necessary amendments to the existing nursing facility and model nursing facility waivers and the state plan under Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.). Any amendments to the existing nursing facility and model nursing facility waivers and the state plan which are deemed to be necessary by the director shall be submitted to the federal Health Care Financing Administration by April 1, 1999.

(i) The department shall implement this section only to the extent that its implementation results in fiscal neutrality, as required under the terms of the waivers.

SEC. 66. Section 16120.05 of the Welfare and Institutions Code is amended to read:

16120.05. The adoption assistance agreement shall, at a minimum, specify the amount and duration of assistance, *and that the amount is subject to any applicable increases pursuant to the cost-of-living adjustments established by statute*. The date for reassessment of the child's needs shall be set at the time of the initial negotiation of the adoption assistance agreement, and shall, thereafter be set at each subsequent reassessment. The interval between any reassessments may not exceed two years.

The adoption assistance agreement shall also specify the responsibility of the adopting family for reporting changes in circumstances that might negatively affect their ability to provide for the identified needs of the child.

SEC. 67. Section 16121 of the Welfare and Institutions Code is amended to read:

~~16121. (a) In accordance with the adoption assistance agreement, the adoptive family shall be paid an amount of aid~~

~~based on the child's needs otherwise covered in AFDC-FC payments and the circumstance of the adopting parents but that shall not exceed the foster care maintenance payment that would have been paid based on the age related state-approved foster family home care rate, and any applicable specialized care increment, for a child placed in a licensed or approved family home pursuant to subdivisions (a) to (d), inclusive, of Section 11461. This subdivision shall only apply to adoption assistance agreements executed before January 1, 2010.~~

16121. (a) (1) For initial adoption assistance agreements executed on October 1, 1992, to December 31, 2007, inclusive, the adoptive family shall be paid an amount of aid based on the child's needs otherwise covered in AFDC-FC payments and the circumstances of the adopting parents, but that shall not exceed the basic foster care maintenance payment rate structure in effect on December 31, 2007, that would have been paid based on the age-related state-approved foster family home rate, and any applicable specialized care increment, for a child placed in a licensed or approved family home.

(2) For initial adoption assistance agreements executed from January 1, 2008, to December 31, 2009, inclusive, the adoptive family shall be paid an amount of aid based on the child's needs otherwise covered in AFDC-FC payments and the circumstances of the adopting parents, but that shall not exceed the basic foster care maintenance payment rate structure in effect on December 31, 2009, that would have been paid based on the age-related state-approved foster family home rate, and any applicable specialized care increment, for a child placed in a licensed or approved family home.

~~(1)~~

(3) Notwithstanding any other provision of this section, for *initial* adoption assistance agreements executed on ~~or after~~ January 1, 2010, *to June 30, 2011, inclusive, or the effective date specified in a final order, for which the time to appeal has passed, issued by a court of competent jurisdiction in California State Foster Parent Association, et al. v. William Lightbourne, et al., (U.S. Dist. Ct. No. C 07-08056 WHA), whichever is earlier, where the adoption is finalized on or before June 30, 2011, or the date specified in that order, whichever is earlier* the adoptive family shall be paid an amount of aid based on the child's needs otherwise

covered in AFDC-FC payments and the circumstance of the adopting parents, but that amount shall not exceed the *basic* foster care maintenance payment *rate structure in effect on June 30, 2011, or the date immediately prior to the date specified in the order described in this paragraph, whichever is earlier,* and any applicable specialized care increment, that the child *would have* received while placed in a licensed or approved family ~~home pursuant to subdivisions (a) to (d), inclusive, of Section 11461~~ *home. Adoption assistance benefit payments shall not be increased based solely on age. This paragraph shall not preclude any reassessments of the child's needs, consistent with other provisions of this chapter*.

~~(2) For adoption assistance agreements executed on or after January 1, 2010, adoption assistance benefits shall not be increased based on age, as occurs for foster family homes pursuant to subdivisions (a) to (d), inclusive, of Section 11461. This paragraph shall not preclude any reassessments of the child's needs, consistent with other provisions of this chapter.~~

(4) Notwithstanding any other provision of this section, for initial adoption assistance agreements executed on or after July 1, 2011, or the effective date specified in a final order, for which the time to appeal has passed, issued by a court of competent jurisdiction in California State Foster Parent Association, et. al. v. William Lightbourne, et al. (U.S. Dist. Ct. No. C 07-05086 WHA), whichever is earlier, where the adoption is finalized on or after July 1, 2011, or the effective date of that order, whichever is earlier, and for initial adoption assistance agreements executed before July 1, 2011, or the date specified in that order, whichever is earlier, where the adoption is finalized on or after the earlier of July 1, 2011, or that specified date, the adoptive family shall be paid an amount of aid based on the child's needs otherwise covered in AFDC-FC payments and the circumstances of the adopting parents, but that amount shall not exceed the basic foster family home rate as set forth in paragraph (1) of subdivision (g) of Section 11461, plus any applicable specialized care increment. These adoption assistance benefit payments shall not be increased based solely on age. This paragraph shall not preclude any reassessments of the child's needs, consistent with other provisions of this chapter.

(b) Payment may be made on behalf of an otherwise eligible child in a state-approved group home or residential care treatment

facility if the department or county responsible for determining payment has confirmed that the placement is necessary for the temporary resolution of mental or emotional problems related to a condition that existed prior to the adoptive placement. Out-of-home placements shall be in accordance with the applicable provisions of Chapter 3 (commencing with Section 1500) of Division 2 of the Health and Safety Code and other applicable statutes and regulations governing eligibility for AFDC-FC payments for placements in in-state and out-of-state facilities. The designation of the placement facility shall be made after consultation with the family by the department or county welfare agency responsible for determining the Adoption Assistance Program (AAP) eligibility and authorizing financial aid. Group home or residential placement shall only be made as part of a plan for return of the child to the adoptive family, that shall actively participate in the plan. Adoption Assistance Program benefits may be authorized for payment for an eligible child's group home or residential treatment facility placement if the placement is justified by a specific episode or condition and does not exceed an 18-month cumulative period of time. After an initial authorized group home or residential treatment facility placement, subsequent authorizations for payment for a group home or residential treatment facility placement may be based on an eligible child's subsequent specific episodes or conditions.

(c) (1) Payments on behalf of a child who is a recipient of AAP benefits who is also a consumer of regional center services shall be based on the rates established by the State Department of Social Services pursuant to Section 11464 and subject to the process described in paragraph (1) of subdivision (d) of Section 16119.

(2) (A) Except as provided for in subparagraph (B), this subdivision shall apply to adoption assistance agreements signed on or after July 1, 2007.

(B) Rates paid on behalf of regional center consumers who are recipients of AAP benefits and for whom an adoption assistance agreement was executed before July 1, 2007, shall remain in effect, and may only be changed in accordance with Section 16119.

(i) If the rates paid pursuant to adoption assistance agreements executed before July 1, 2007, are lower than the rates specified in paragraph (1) of subdivision (c) or paragraph (1) of subdivision (d) of Section 11464, respectively, those rates shall be increased,

as appropriate and in accordance with Section 16119, to the amount set forth in paragraph (1) of subdivision (c) or paragraph (1) of subdivision (d) of Section 11464, effective July 1, 2007. Once set, the rates shall remain in effect and may only be changed in accordance with Section 16119.

(ii) For purposes of this clause, for a child who is a recipient of AAP benefits or for whom the execution of an AAP agreement is pending, and who has been deemed eligible for or has sought an eligibility determination for regional center services pursuant to subdivision (a) of Section 4512, and for whom a determination of eligibility for those regional center services has been made, and for whom, prior to July 1, 2007, a maximum rate determination has been requested and is pending, the rate shall be determined through an individualized assessment and pursuant to subparagraph (C) of paragraph (1) of subdivision (c) of Section 35333 of Title 22 of the California Code of Regulations as in effect on January 1, 2007, or the rate established in subdivision (b) of Section 11464, whichever is greater. Once the rate has been set, it shall remain in effect and may only be changed in accordance with Section 16119. Other than the circumstances described in this clause, regional centers shall not make maximum rate benefit determinations for the AAP.

(3) Regional centers shall separately purchase or secure the services contained in the child's IFSP or IPP, pursuant to Section 4684.

(4) Regulations adopted by the department pursuant to this subdivision shall be adopted as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and for the purposes of that chapter, including Section 11349.6 of the Government Code, the adoption of these regulations is an emergency and shall be considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health, safety, and general welfare. The regulations authorized by this paragraph shall remain in effect for no more than 180 days, by which time final regulations shall be adopted.

(d) (1) In the event that a family signs an adoption assistance agreement where a cash benefit is not awarded, the adopting family shall be otherwise eligible to receive Medi-Cal benefits for the

child if it is determined that the benefits are needed pursuant to this chapter.

(2) Regional centers shall separately purchase or secure the services that are contained in the child's Individualized Family Service Plan (IFSP) or Individual Program Plan (IPP) pursuant to Section 4684.

(e) Subdivisions (a), (b), and (d) shall apply only to adoption assistance agreements signed on or after October 1, 1992. *An adoption assistance agreement executed prior to October 1, 1992, shall continue to be paid in accordance with the terms of that agreement, and shall not be eligible for any increase in the basic foster care maintenance rate structure that occurred after December 31, 2007.*

(f) This section shall supersede the requirements of subparagraph (C) of paragraph (1) of Section 35333 of Title 22 of the California Code of Regulations.

(g) The adoption assistance payment rate structure identified in subdivisions (a) and (e) shall be adjusted by the percentage changes in the California Necessities Index, beginning with the 2011–12 fiscal year, and shall not require a reassessment.

SEC. 68. Section 16121.01 of the Welfare and Institutions Code is repealed.

~~16121.01. Notwithstanding any other provision of law, the amount of aid to be paid to an adoptive family for any adoption assistance agreement executed prior to October 1, 1992, or the foster care maintenance payment based on the age-related, state-approved foster family home care rate and any applicable specialized care increment that would have been paid to an adoptive family for an adoption assistance agreement executed prior to January 1, 2008, shall not be adjusted pursuant to the rate increase specified in subparagraph (C) of paragraph (1) of subdivision (d) of Section 11461 in any subsequent reassessment on or after January 1, 2008.~~

SEC. 69. Section 16519.5 of the Welfare and Institutions Code is amended to read:

16519.5. (a) The State Department of Social Services, in consultation with county child welfare agencies, foster parent associations, and other interested community parties, shall implement a pilot program to establish a unified, family friendly, and child-centered resource family approval process to replace the

existing multiple processes for licensing foster family homes, approving relatives and nonrelative extended family members as foster care providers, and approving adoptive families.

(b) Up to five counties shall be selected to participate on a voluntary basis in the pilot program, according to criteria developed by the department in consultation with the County Welfare Directors Association. In selecting the pilot counties, the department shall promote diversity among the participating counties in terms of size and geographic location.

(c) (1) For the purposes of this section, "resource family" means an individual or couple that a participating county determines to have successfully met both the home approval standards and the permanency assessment criteria adopted pursuant to subdivision (d) necessary for providing care for a related or unrelated child who is under the jurisdiction of the juvenile court, or otherwise in the care of a county child welfare agency or probation department. A resource family shall demonstrate all of the following:

(A) An understanding of the safety, permanence, and well-being needs of children who have been victims of child abuse and neglect, and the capacity and willingness to meet those needs, including the need for protection, and the willingness to make use of support resources offered by the agency, or a support structure in place, or both.

(B) An understanding of children's needs and development, effective parenting skills or knowledge about parenting, and the capacity to act as a reasonable, prudent parent in day-to-day decisionmaking.

(C) An understanding of his or her role as a resource family and the capacity to work cooperatively with the agency and other service providers in implementing the child's case plan.

(D) The financial ability within the household to ensure the stability and financial security of the family.

(E) An ability and willingness to maintain the least restrictive and most familylike environment that serves the needs of the child.

(2) Subsequent to meeting the criteria set forth in this subdivision and designation as a resource family, a resource family shall be considered eligible to provide foster care for related and unrelated children in out-of-home placement, shall be considered approved for adoption or guardianship, and shall not have to

undergo any additional approval or licensure as long as the family lives in a county participating in the pilot program.

(3) Resource family assessment and approval means that the applicant meets the standard for home approval, and has successfully completed a permanency assessment. This approval is in lieu of the existing foster care license, relative or nonrelative extended family member approval, and the adoption home study approval.

(4) Approval of a resource family does not guarantee an initial or continued placement of a child with a resource family.

(d) Prior to implementation of this pilot program, the department shall adopt standards pertaining to home approval and permanency assessment of a resource family.

(1) Resource family home approval standards shall include, but not be limited to, all of the following:

(A) (i) Criminal records clearance of all adults residing in the home, pursuant to Section 8712 of the Family Code, utilizing a check of the Child Abuse Central Index (CACI), a check of the Child Welfare Services/Case Management System (CWS/CMS), receipt of a fingerprint-based state criminal offender record information search response, and submission of a fingerprint-based federal criminal offender record information search.

(ii) Consideration of any prior allegations of child abuse or neglect against either the applicant or any other adult residing in the home. An approval may not be granted to applicants whose criminal record indicates a conviction for any of the offenses specified in clause (i) of subparagraph (A) of paragraph (1) of subdivision (g) of Section 1522 of the Health and Safety Code.

(iii) Exemptions from the criminal records clearance requirements set forth in this section may be granted by the director or the pilot county, if that county has been granted permission by the director to issue criminal records exemptions pursuant to Section 316.4, using the exemption criteria currently used for foster care licensing as specified in subdivision (g) of Section 1522 of the Health and Safety Code.

(B) Buildings and grounds, outdoor activity space, and storage requirements set forth in Sections 89387, 89387.1, and 89387.2 of Title 22 of the California Code of Regulations.

(C) In addition to the foregoing requirements, the resource family home approval standards shall also require the following:

(i) That the applicant demonstrate an understanding about the rights of children in care and his or her responsibility to safeguard those rights.

(ii) That the total number of children residing in the home of a resource family shall be no more than the total number of children the resource family can properly care for, regardless of status, and shall not exceed six children, unless exceptional circumstances that are documented in the foster child's case file exist to permit a resource family to care for more children, including, but not limited to, the need to place siblings together.

(iii) That the applicant understands his or her responsibilities with respect to acting as a reasonable and prudent parent, and maintaining the least restrictive and most family-like environment that serves the needs of the child.

(D) The results of a caregiver risk assessment are consistent with the factors listed in subparagraphs (A) to (D), inclusive, of paragraph (1) of subdivision (c). A caregiver risk assessment shall include, but not be limited to, physical and mental health, alcohol and other substance use and abuse, and family and domestic violence.

(2) The resource family permanency assessment standards shall include, but not be limited to, all of the following:

(A) The applicant shall complete caregiver training.

(B) The applicant shall complete a psychosocial evaluation.

(C) The applicant shall complete any other activities that relate to a resource family's ability to achieve permanency with the child.

(e) (1) A child may be placed with a resource family that has received home approval prior to completion of a permanency assessment only if a compelling reason for the placement exists based on the needs of the child.

(2) The permanency assessment shall be completed within 90 days of the child's placement in the approved home, unless good cause exists based upon the needs of the child.

(3) If additional time is needed to complete the permanency assessment, the county shall document the extenuating circumstances for the delay and generate a timeframe for the completion of the permanency assessment.

(4) The county shall report to the department on a quarterly basis the number of families with a child in an approved home

whose permanency assessment goes beyond 90 days and summarize the reasons for these delays.

(5) A child may be placed with a relative, as defined in Section 319, or nonrelative extended family member, as defined in Section 362.7, prior to home approval and completion of the permanency assessment only on an emergency basis if all of the following requirements are met:

(A) Consideration of the results of a criminal records check conducted pursuant to Section 16504.5 of the relative or nonrelative extended family member and of every other adult in the home.

(B) Consideration of the results of the Child Abuse Central Index (CACI) consistent with Section 1522.1 of the Health and Safety Code of the relative or nonrelative extended family member, and of every other adult in the home.

(C) The home and grounds are free of conditions that pose undue risk to the health and safety of the child.

(D) For any placement made pursuant to this paragraph, the county shall initiate the home approval process no later than five business days after the placement, which shall include a face-to-face interview with the resource family applicant and child.

(E) For any placement made pursuant to this paragraph, AFDC-FC funding shall not be available until the home has been approved.

(F) Any child placed under this section shall be afforded all the rights set forth in Section 16001.9.

(f) The State Department of Social Services shall be responsible for all of the following:

(1) Selecting pilot counties, based on criteria established by the department in consultation with the County Welfare Directors Association.

(2) Establishing timeframes for participating counties to submit an implementation plan, enter into terms and conditions for participation in the pilot program, train appropriate staff, and accept applications from resource families.

(3) Entering into terms and conditions for participation in the pilot program by counties.

(4) Administering the pilot program through the issuance of written directives that shall have the same force and effect as regulations. Any directive affecting Article 1 (commencing with Section 700) of Chapter 7 of Title 11 of the California Code of

Regulations shall be approved by the Department of Justice. The directives shall be exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340)) of Part 1 of Division 3 of Title 2 of the Government Code.

(5) Approving and requiring the use of a single standard for resource family home approval and permanency assessment.

(6) Adopting and requiring the use of standardized documentation for the home approval and permanency assessment of resource families.

(7) Requiring counties to monitor resource families including, but not limited to, all of the following:

(A) Investigating complaints of resource families.

(B) Developing and monitoring resource family corrective action plans to correct identified deficiencies and to rescind resource family approval if compliance with corrective action plans is not achieved.

(8) Ongoing oversight and monitoring of county systems and operations including all of the following:

(A) Reviewing the county's implementation of the pilot program.

(B) Reviewing an adequate number of approved resource families in each participating county to ensure that approval standards are being properly applied. The review shall include case file documentation, and may include onsite inspection of individual resource families. The review shall occur on an annual basis, and more frequently if the department becomes aware that a participating county is experiencing a disproportionate number of complaints against individual resource family homes.

(C) Reviewing county reports of serious complaints and incidents involving approved resource families, as determined necessary by the department. The department may conduct an independent review of the complaint or incident and change the findings depending on the results of its investigation.

(D) Investigating unresolved complaints against participating counties.

(E) Requiring corrective action of counties that are not in full compliance with the terms and conditions of the pilot program.

(9) Terminating the participation of any county that fails to make corrective action or who otherwise violates the terms and conditions of participation in the pilot program.

(10) Preparing or having prepared within 180 days after the conclusion of the pilot program, and submitting to the Legislature, a report on the results of the pilot program. The report shall include all of the following:

(A) An analysis, utilizing available data, of state and federal data indicators related to the length of time to permanency including reunification, guardianship and adoption, child safety factors, and placement stability.

(B) An analysis of resource family recruitment and retention elements, including resource family satisfaction with approval processes and changes regarding the population of available resource families.

(C) An analysis of cost, utilizing available data, including funding sources.

(D) An analysis of regulatory or statutory barriers to implementing the pilot program on a statewide basis.

(g) Counties participating in the pilot program shall be responsible for all of the following:

(1) Submitting an implementation plan, entering into terms and conditions for participation in the pilot program, consulting with the county probation department in the development of the implementation plan, training appropriate staff, and accepting applications from resource families within the timeframes established by the department.

(2) Complying with the written directives pursuant to paragraph (4) of subdivision (f).

(3) Implementing the requirements for resource family home approval and permanency assessment and utilizing standardized documentation established by the department.

(4) Ensuring staff have the education and experience necessary to complete the home approval and permanency assessment competently.

(5) Approving and denying resource family applications, including all of the following:

(A) Rescinding home approvals and resource family approvals where appropriate, consistent with the established standard.

(B) Providing disapproved resource families requesting review of that decision due process by conducting county grievance reviews pursuant to the department's regulations.

(C) Notifying the department of any decisions denying a resource family's application or rescinding the approval of a resource family.

(6) Updating resource family approval annually.

(7) Monitoring resource families through all of the following:

(A) Ensuring that social workers who identify a condition in the home that may not meet the approval standards set forth in subdivision (d) while in the course of a routine visit to children placed with a resource family take appropriate action as needed.

(B) Requiring resource families to comply with corrective action plans as necessary to correct identified deficiencies. If corrective action is not completed as specified in the plan, the county may rescind the resource family approval.

(C) Requiring resource families to report to the county child welfare agency any incidents consistent with the reporting requirements for licensed foster family homes.

(8) Investigating all complaints against a resource family and taking action as necessary. This shall include investigating any incidents reported about a resource family indicating that the approval standard is not being maintained.

(A) The child's social worker shall not conduct the formal investigation into the complaint received concerning a family providing services under the standards required by subdivision (d). To the extent that adequate resources are available, complaints shall be investigated by a worker who did not initially perform the home approval or permanency assessment.

(B) Upon conclusion of the complaint investigation, the final disposition shall be reviewed and approved by a supervising staff member.

(C) The department shall be notified of any serious incidents or serious complaints or any incident that falls within the definition of Section 11165.5 of the Penal Code. If those incidents or complaints result in an investigation, the department shall also be notified as to the status and disposition of that investigation.

(9) Performing corrective action as required by the department.

(10) Assessing county performance in related areas of the California Child and Family Services Review System, and remedying problems identified.

(11) Submitting information and data that the department determines is necessary to study, monitor, and prepare the report specified in paragraph (10) of subdivision (f).

(h) Approved relatives and nonrelated extended family members, licensed foster family homes, or approved adoptive homes that have completed the license or approval process prior to full implementation of the pilot program shall not be considered part of the pilot program. The otherwise applicable assessment and oversight processes shall continue to be administered for families and facilities not included in the pilot program.

(i) Upon completion of the pilot program, the status of the resource family's approval shall continue in full force and effect, and the resource family shall be deemed approved for licensing, relative and nonrelated extended family member approval, guardianship, and adoption purposes.

(j) The department may waive regulations that pose a barrier to implementation and operation of this pilot program. The waiver of any regulations by the department pursuant to this section shall apply to only those counties participating in the pilot program and only for the duration of the pilot program.

(k) Resource families approved under this pilot program, who move within a participating county or who move to another pilot program county, shall retain their resource family status if the new building and grounds, outdoor activity areas, and storage areas meet home approval standards. The State Department of Social Services or pilot county may allow a pilot program-affiliated individual to transfer his or her subsequent arrest notification if the individual moves from one pilot county to another pilot county, as specified in subdivision (h) of Section 1522 of the Health and Safety Code.

(*l*) (1) A resource family approved under this pilot program that moves to a nonparticipating pilot program county shall lose its status as a resource family. The new county of residence shall deem the family approved for licensing, relative and nonrelated extended family member approval, guardianship, and adoption purposes, under the following conditions:

(A) The new building and grounds, outdoor activity areas, and storage areas meet applicable standards, unless the family is subject to a corrective action plan.

(B) There has been a criminal records clearance of all adults residing in the home and exemptions granted, using the exemption criteria currently used for foster care licensing, as specified in subdivision (g) of Section 1522 of the Health and Safety Code.

(2) A program-affiliated individual who moves to a nonpilot county may not transfer his or her subsequent arrest notification from a pilot county to the nonpilot county.

(m) Implementation of the pilot program shall be contingent upon the continued availability of federal Social Security Act Title IV-E (42 U.S.C. Sec. 670) funds for costs associated with placement of children with resource families assessed and approved under the program.

(n) Notwithstanding Section 11402, a child placed with a resource family shall be eligible for AFDC-FC payments. A resource family shall be paid an AFDC-FC rate pursuant to Sections 11460 and 11461. Sharing ratios for nonfederal expenditures for all costs associated with activities related to the approval of relatives and nonrelated extended family members shall be in accordance with Section 10101.

(o) The Department of Justice shall charge fees sufficient to cover the cost of initial or subsequent criminal offender record information and Child Abuse Central Index searches, processing, or responses, as specified in this section.

(p) Approved resource families under this pilot program shall be exempt from all of the following:

(1) Licensure requirements set forth under the Community Care Facilities Act, commencing with Section 1500 of the Health and Safety Code and all regulations promulgated thereto.

(2) Relative and nonrelative extended family member approval requirements set forth under Sections 309, 361.4, and 362.7, and all regulations promulgated thereto.

(3) Adoptions approval and reporting requirements set forth under Section 8712 of the Family Code, and all regulations promulgated thereto.

(q) The pilot program shall be authorized to continue through the end of the 2010–11 fiscal year, or through the end of the ~~third~~

fifth full fiscal year following the date that funds are made available for its implementation, whichever of these dates is later.

(r) Notwithstanding subdivision (q), implementation of this section is suspended until January 1, 2012.

SEC. 70. Section 17021 of the Welfare and Institutions Code, as amended by Section 40 of Chapter 8 of the Statutes of 2011, is amended to read:

17021. (a) Any individual who is not eligible for aid under Chapter 2 (commencing with Section 11200) of Part 3 as a result of the ~~48- or 60-month~~ *48-month* limitation specified in subdivision (a) of Section 11454 shall not be eligible for aid or assistance under this part until all of the children of the individual on whose behalf aid was received, whether or not currently living in the home with the individual, are 18 years of age or older.

(b) Any individual who is receiving aid under Chapter 2 (commencing with Section 11200) of Part 3 on behalf of an eligible child, but who is either ineligible for aid or whose needs are not otherwise taken into account in determining the amount of aid to the family pursuant to Section 11450 due to the imposition of a sanction or penalty, shall not be eligible for aid or assistance under this part.

(c) This section shall not apply to health care benefits provided under this part.

SEC. 71. (a) By January 10, 2012, the State Department of Social Services, in partnership with the Office of Systems Integration and stakeholders, including legislative staff and counties, shall do all of the following:

(1) Determine and describe the degree to which the Child Welfare Services Case Management System (CWS/CMS) satisfies all of the following requirements:

(A) Complies with applicable existing law, regulation, and policy.

(B) Supports existing child welfare services practice, including, but not limited to, key child welfare services functions, ease of access to case and service information, multidisciplinary case management, and ease of use.

(C) Links to information that enhances investigation, case management, or efficiency.

(D) Provides ready access to data for reporting, planning, management, and program outcome monitoring.

(2) Determine the best approach or approaches to address any missing functionalities that are critical to child welfare services operations. Options shall include building functionality into the existing CWS/CMS, restarting the CWS/Web procurement, or developing a new procurement.

(3) Assess and report on communication from the federal government regarding system requirements, both by the January 10, 2012, deadline, and thereafter, when the department receives additional direction regarding federal requirements.

(4) Recommend next steps, including a timeline, for implementing approaches identified pursuant to paragraph (2).

(b) (1) The requirement for submitting a report imposed under subdivision (a) is inoperative on January 10, 2016, pursuant to Section 10231.5 of the Government Code.

(2) A report to be submitted pursuant to subdivision (a) shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 72. The State Department of Social Services, in consultation with stakeholders including, but not limited to, counties and public authorities, including representatives of the California Association of Public Authorities, shall develop a new rate-setting methodology for public authority administrative costs, to go into effect commencing with the 2012–13 fiscal year.

SEC. 73. Sections 1 to 40, inclusive, of this act shall become operative on January 1, 2012.

SEC. 74. It is the intent of the Legislature that foster care rates increased pursuant to a final order, for which the time to appeal has passed, by a court of competent jurisdiction in California State Foster Parent Association, et al. v. William Lightbourne, et al. (U.S. Dist. Ct. No. C. 07-05086 WHA) shall be retroactive to the date specified in that order.

SEC. 75. (a) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement and administer Sections 45, 47 to 50, inclusive, 52, 53, 55, and 66 to 68, inclusive, of this act, through all-county letters or similar instructions from the department until regulations are adopted. The department shall adopt emergency regulations implementing these provisions no later than July 1, 2012. The department may readopt any

emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(b) The initial adoption of emergency regulations pursuant to this section and one readoption of emergency regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

SEC. 76. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 77. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

All matter omitted in this version of the bill appears in the bill as amended in the Senate, March 14, 2011. (JR11)

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